THE MEDICARE 1992 HANDBOOK

INCLUDING INFORMATION FOR BENEFICIARIES ON:

- ★ MEDICARE BENEFITS
- ★ PARTICIPATING PHYSICIANS AND SUPPLIERS
- ★ HEALTH INSURANCE TO SUPPLEMENT MEDICARE
- ★ LIMITS TO MEDICARE COVERAGE

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

IF YOU HAVE QUESTIONS

About	Examples	Contact
Enrollment in Medicare A and B	How do I enroll in Medicare? I lost my card, what should I do?	Social Security 1-800-772-1213
Who pays first	I have other health insurance in addition to Medicare.	Your employer or the provider of service (see pages 9 and 10 for more information).
Part B payments	How much will Medicare pay on my last doctor bill? When will I get an explanation of Medicare benefits?	Part B carrier (listed by state on pages 36 to 41).
Doctors who take assignment on all claims	Where can I get a list of the participating physicians in my area?	Part B carrier (listed by state on pages 36 to 41).
Quality of care	I think I was discharged too soon from the hospital. I developed a lung infection in the hospital while I was being treated for a broken hip.	PRO (listed by state on pages 42 to 46). Do **not** call the PRO with questions about your Medicare bills.
Part A payments	I got a statement from the hospital. Will Medicare pay my whole bill?	The staff at the hospital, nursing home or other facility. (See 'Intermediaries and Carriers' on page 2 for more information.)
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Reporting Medigap fraud	I was sold a policy that provides benefits I already have with Medicare.	Your state insurance department (see pages 8 and 9 for more information) **and** call Medicare at 1-800-638-6833.
Financial assistance	I don't have enough money to pay my Medicare premium or coinsurance. Can I get help?	Your state or local welfare, social service or public health agency (see pages 4 and 5 for more information).
Reporting Medicare fraud	I was billed for a service I did not get.	Medicare carrier or intermediary first (see page 4 for more information).

ABOUT THIS HANDBOOK

Medicare pays for many of your health care expenses, but **it does not cover all of them**. It is important for you to know what Medicare does and does not pay for. This handbook will help you understand how the Medicare program works and what your benefits are. You can use the alphabetical index at the back of the book to find information on specific subjects. This handbook is also available in Spanish. (See inside back cover for how to order.)

Don't Miss

❑ **The Assignment Method of Payment**

Many doctors and suppliers have agreed to be part of Medicare's participating physician and supplier program. They accept assignment on all Medicare claims. If you get your medical services from one of these participating doctors or suppliers, you can often save money. See page 26 for more information about the assignment method of payment, and what you can do to find a participating doctor or supplier.

❑ **Your Appeal Rights**

You will find an important message about your rights on pages 47 and 48. Pages 32 and 33 explain how to appeal when Medicare does not pay your Part A or Part B claims.

❑ **If You Need Financial Assistance to Pay for Health Care**

Sometimes you can get help paying for Medicare. Look on page 4 for more information.

❑ **New Information About Insurance to Supplement Medicare**

Some people want to have insurance to pay medical bills Medicare doesn't cover. See pages 8 and 9 to find out about Medicare supplement "Medigap" insurance, including a new open enrollment period.

❑ **New Benefits**

Recently added Medicare Part B benefits for cancer screening—mammograms and Pap smears—are described on page 23.

❑ **Who Pays First?**

Medicare is not always the insurer that pays first on claims. Some people are employed, for example, or their spouse is employed, and the employer health insurance pays first. For more about who pays first, see pages 9 and 10.

❑ **Where to Call or Write**

Look on the inside front cover to find where to call or write to ask questions about Medicare.

This handbook is meant to explain the Medicare program, but is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations and rulings.

Contents

What is Medicare?

The Medicare program is a federal health insurance program for people 65 or older and certain disabled people. It is run by the Health Care Financing Administration of the U.S. Department of Health and Human Services. Social Security Administration offices across the country take applications for Medicare and provide general information about the program.

The Two Parts of Medicare

There are two parts to the Medicare program. **Hospital Insurance (Part A)** helps pay for inpatient hospital care, inpatient care in a skilled nursing facility, home health care and hospice care. **Medical Insurance (Part B)** helps pay for doctors' services, outpatient hospital services, durable medical equipment, and a number of other medical services and supplies that are not covered by the hospital insurance part of Medicare. Throughout this handbook, Medicare Hospital Insurance will be referred to as Part A and Medicare Medical Insurance will be referred to as Part B.

Part A has deductibles and coinsurance, but most people do not have to pay premiums for Part A (see page 30). Part B of Medicare has premiums, deductibles, and coinsurance amounts that you must pay yourself or through coverage by another insurance plan. Premium, deductible and coinsurance amounts are set each year according to formulas established by law. New payment amounts begin each January 1. When amounts increase, you will be notified. For 1992 deductible, premium and coinsurance amounts, see the charts on pages 34 and 35 of this handbook.

Who Can Get Medicare Hospital Insurance (Part A)?

Generally, people age 65 and over can get premium-free Medicare Part A benefits, based on their own or their spouses' employment. (Premium-free means there are no monthly premiums. Most people do not pay premiums for Medicare Part A.) You can get premium-free Medicare Part A if you are 65 or over and any of these three statements is true:

- You receive benefits under the Social Security or Railroad Retirement system.
- You could receive benefits under Social Security or the Railroad Retirement system but have not filed for them.
- You or your spouse had Medicare-covered government employment.

If you are under 65, you can get premium-free Medicare Part A benefits if you have been a disabled beneficiary under Social Security or the Railroad Retirement Board for more than 24 months.

Certain government employees and certain members of their families can also get Medicare when they are disabled for more than 29 months. They should apply with the Social Security Administration as soon as they become disabled.

Or, you may be able to get premium-free Medicare Part A benefits if you receive continuing dialysis for permanent kidney failure or if you have had a kidney transplant. (People who can get Medicare because of kidney disease may get a copy of *Medicare Coverage of Kidney Dialysis and Kidney Transplant Services* from the Consumer Information Center. See inside back cover for how to order.)

Check with Social Security to see if you have worked long enough under Social Security, Railroad Retirement, as a government employee, or a combination of these systems to be able to get Medicare Part A benefits. Generally, if either you or your spouse worked for 10 years, you will be able to get premium-free Medicare Part A benefits.

Who Can Get Medicare Medical Insurance (Part B)?

Any person who can get premium-free Medicare Part A benefits based on work as described above can enroll for Part B, pay the monthly Part B premiums (in 1992, $31.80 for most beneficiaries), and get Part B benefits. In addition, most United States residents age 65 or over can enroll in Part B.

Buying Medicare Part A and Part B

If you do not have enough work credits to be able to get Medicare Part A benefits and you are 65 or over, you may be able to buy Medicare Parts A and B—or just Medicare Part B—by paying monthly premiums. Also, you may be able to buy Medicare Parts A and B if you are disabled and lost your premium-free Part A solely because you are working. (See page 31 for more information.)

Enrollment in Medicare

If you are already getting Social Security or Railroad Retirement benefit payments when you turn 65, you will automatically get a Medicare card in the mail. The card will show that you can get both Medicare Hospital Insurance (Part A) and Medical Insurance (Part B) benefits. If you do not want Part B, follow the instructions that come with the card.

The above process also applies when you have been a disability beneficiary under Social Security or Railroad Retirement for 24 months. A Medicare card will come in the mail.

Some people do not automatically get a Medicare card. They must file an application to get Medicare benefits. If you have not applied for Social Security or Railroad Retirement benefits, or if government employment is involved, or if you have kidney disease, you must file an application for Medicare. Check with Social Security if you are able to get Medicare under the Social Security system or based on Medicare-covered government employment; check with the Railroad Retirement office if you are able to get Medicare under the Railroad Retirement system.

If you must file an application for Medicare, you should do so during your initial enrollment period, to avoid late enrollment penalties under Medicare Part B (unless you qualify for a special enrollment period as described on page 30). Your initial enrollment period is a seven-month period that starts three months before the month you first meet the requirements for Medicare. If you do not sign up for Medicare during the first three months of your initial enrollment period, there will be a delay in starting your Part B coverage. Your coverage will be delayed from one to three months after enrollment.

If you do not enroll for Medicare Part B **at any time** during your initial enrollment period, you will not get another chance to enroll until the next general enrollment period. A general enrollment period is held each year from January 1 through March 31. You may also be charged a premium penalty for late enrollment (unless you qualify for a special enrollment period as described on page 30).

The enrollment period requirements and penalties for late enrollment described above for Part B also apply to people who buy Part A. (See page 30 for more information about buying Medicare Part A.)

Your Medicare Card

The Medicare card shows the Medicare coverage you have—Hospital Insurance (Part A), Medical Insurance (Part B), or both—and the date your protection started. If you do not have both parts of Medicare, see page 30 for information on how you can get the part you don't have.

Your Medicare card also shows your health insurance claim number. Sometimes this claim number is referred to as your Medicare number. The claim number usually has nine digits and one or two letters. There may also be another number after the letter. Your full claim number must always be included on all Medicare claims and correspondence. When a husband and wife both have Medicare, each receives a separate card and claim number. Each spouse must use the exact name and claim number shown on his or her card.

It is important that you remember to:

- Use your Medicare card only after the effective date shown on it.
- Keep your card handy. And be sure to carry your card with you whenever you are away from home.
- Always show your Medicare card when you receive services that Medicare helps pay for.
- Always write your health insurance claim number (including any letters) on all checks for Medicare premium payments or any correspondence about Medicare. Also, you should have your Medicare card available when you make a telephone inquiry.
- Immediately ask Social Security to get you a new card if you lose yours.
- Never let anyone else use your Medicare card.

Intermediaries and Carriers

The federal government contracts with private insurance organizations called **intermediaries** and **carriers** to process claims and make Medicare payments.

Intermediaries handle claims submitted on your behalf by hospitals. They also handle inpatient and outpatient claims submitted on your behalf by skilled nursing facilities, home health agencies, hospices and other providers of services.

You will not usually need to get in touch with intermediaries because Medicare pays most hospitals, skilled nursing facilities, home health agencies, hospices and other providers of services directly. But, if you have

a question about your Part A bill, ask someone who works at the facility for help. If you cannot get an answer there, ask someone in the billing office at the facility to help you get in touch with the Medicare intermediary.

Carriers handle claims for services by doctors and other suppliers covered under Medicare's Part B program. If you have questions about Medicare Part B claims, you can contact your Medicare carrier. The addresses and phone numbers of carriers are on pages 36 to 41.

Peer Review Organizations

Peer Review Organizations (PROs) are groups of practicing doctors and other health care professionals who are paid by the federal government to review the care given to Medicare patients. Each state has a PRO that decides, for Medicare payment purposes, whether care is reasonable, necessary, and provided in the most appropriate setting. PROs also decide whether care meets the standards of quality generally accepted by the medical profession. PROs have the authority to deny payments if care is not medically necessary or not delivered in the most appropriate setting.

PROs investigate individual patient complaints about the quality of care. PROs also respond to requests for review of notices of noncoverage issued by hospitals to beneficiaries; and PROs respond to beneficiary, physician, and hospital requests for reconsideration of PRO decisions.

If you are admitted to a Medicare participating hospital, you will receive *An Important Message From Medicare* which explains your rights as a hospital patient and provides the name, address and phone number of the PRO for your state. A copy of the message is printed on page 47.

If you feel that you are improperly refused admission to a hospital or that you are forced to leave the hospital too soon, ask for a written explanation of the decision. Such a written notice must fully explain how you can appeal the decision and it must give you the name, address and phone number of the PRO where your appeal or request for review can be submitted. (See page 32 for further discussion of your appeal rights under Medicare.)

Beneficiary Complaints

PROs are responsible for reviewing beneficiary complaints about the quality of care provided by inpatient hospitals, hospital outpatient departments and hospital emergency rooms; skilled nursing facilities; home health agencies; ambulatory surgical centers; and certain health maintenance organizations.

If you believe that you have received poor quality care provided by one of these facilities, you may complain to the PRO. The PRO will investigate written complaints from beneficiaries, or their representatives, about the quality of Medicare services received.

Your complaint must be in writing. If you wish, the PRO will help you put your complaint in writing by taking the information from you over the telephone and writing the complaint. If someone other than the PRO makes a complaint for you or on your behalf, you must give written permission for that person to represent you in the complaint.

Medicare PROs for each state are listed on pages 42 to 46.

Your Right to Decide About Your Medical Care

Under a new Medicare law, when you are admitted to a Medicare hospital or skilled nursing facility, get Medicare home health care, or enroll in a Medicare-certified hospice or health maintenance organization, **you must be given written information about your rights to make decisions about your medical care.**

Generally, you will be told about your right to accept or refuse medical or surgical treatment. You will also be told about your right to make—if you choose—an "advance directive." An advance directive contains written instructions that state your choices for health care or name someone to make those choices for you. The instructions are to be used if you are too sick or otherwise unable to talk. (The paper giving your health care choices may be called a "living will" or "a durable power of attorney for health care.")

You do not have to have an advance directive. But, if you have one you can say "yes" in advance to treatment you want if you get too sick to talk to your health care provider. You can also say "no" in advance to treatment you don't want.

Laws governing advance directives vary from state to state. Your treatment choices will depend on what is legal in your state. You can ask health care professionals in your state about the state's rules for living wills or durable powers of attorney. You can also contact someone in your local state's attorney's office for this information.

Fraud and Abuse

Suspected Fraud Should be Reported

If you have reason to believe that a doctor, hospital, or other provider of health care services is performing unnecessary or inappropriate services, or is billing Medicare for services you did not receive, you should immediately report to the Medicare carrier or intermediary (see page 2) that handles your claims.

If you are offered free items or services, you should immediately report the offer to the Medicare carrier or intermediary. The routine waiver of deductibles and coinsurance by doctors or suppliers of durable medical equipment is unlawful. Coinsurance and deductible payments may be forgiven only after careful consideration of a particular patient's financial hardship.

Report to the Medicare Carrier or Intermediary First

Call the carrier or intermediary first when you suspect fraud. The telephone number of the Medicare intermediary or carrier is listed on the notice explaining Medicare's decision on your Medicare claim. Medicare carriers are also listed on pages 36 to 41.

Reporting to the Inspector General

If the Medicare carrier or intermediary does not respond adequately to your report of Medicare fraud or abuse, you should call the Department of Health and Human Services, Office of Inspector General toll-free Hotline (1-800-368-5779). There is no charge to you when you call this number.

Be prepared to tell the operator:

- The exact nature of the wrongdoing you suspect; the date it occurred, and the name and address of the party involved.
- The name and location of the Medicare intermediary or carrier you reported it to, and when you reported it.
- The name of any intermediary or carrier employee to whom you spoke and what advice that person gave you.

You may also report this information to the Office of Inspector General by writing to: OIG Hotline, P.O. Box 17303, Baltimore, Maryland, 21203-7303.

Call or write your Medicare intermediary or carrier **first** for faster action. **Do not** call the Inspector General Hotline for Medicare policy questions or questions about delayed claims or payments.

If You Belong to an HMO

If you belong to an HMO and you have reason to believe that your HMO did not give you necessary care, inappropriately disenrolled you, charged you an excessive premium, or falsified or misrepresented information, report directly to the Office of Inspector General at the telephone number or address given above. Also report to the Office of the Inspector General if an HMO refuses to enroll you or discourages your enrollment because of your health or because of your need for medical services.

Assistance for Low-Income Beneficiaries

By federal law, state Medicaid programs must pay Medicare costs for certain elderly and disabled people who have low incomes and very limited resources. (Resources are described below.)

You may qualify for this assistance even if you did not work long enough to be able to get premium-free hospital insurance under Part A of Medicare. (If you did not work long enough to be able to get premium-free hospital insurance, and you qualify in all other ways, the state will pay your Part A premiums.)

If you qualify, you will not usually have to pay any of your own money for Medicare premiums, deductibles and coinsurance.

To Qualify

- You must be able to get Medicare Hospital Insurance (Part A).
- Your annual income level must be near the national poverty guidelines. Poverty guidelines for 1992 are set at $6,810 for one person and $9,190 for a family of two.
- You cannot have resources such as bank accounts or stocks and bonds worth more than $4,000 for an individual or $6,000 for a couple. When it considers your resources, your state does not count your personal home, automobile, burial plot, furniture, jewelry, or life insurance, unless those items are of extraordinary value.

Where to Apply

If you think you may qualify for assistance, and you already have Medicare Part A, you should file an application at the state or local welfare, social service or public

health agency that serves people on Medicaid. **All of these agencies are state—not federal—agencies.**

If you think you may qualify for assistance but you do not already have Medicare Part A, you should contact Social Security. You may need to file an application for Medicare Part A.

What to Ask For

When you contact the state or local Medicaid office, ask about the Qualified Medicare Beneficiary program or the Medicare Buy-In program. Explain that you think you qualify for help in paying your Medicare costs and you want to know when and where you can file an application.

Your Rights Under Data Matching

In 1988, Congress passed a law that allows computer matching of the information that you give to the government. You should be aware that when the government collects or uses information about you, it must act under specific guidelines to protect your privacy. The government must:

- Tell you, at the time the information is collected, why the information is needed and how it will be used.
- Make sure personal information is used only for the reasons given, or seek your permission when another purpose for its use is considered necessary or desirable.
- Allow you to see the records kept on you.
- Provide you with the opportunity to correct inaccuracies in the records kept about you.

(A data match using Medicare, Internal Revenue Service and Social Security information is discussed on page 10.)

Medicare Coordinated Care Plans

What Are Coordinated Care Plans?

More and more Medicare beneficiaries are joining coordinated care plans. These coordinated care plans are prepaid, managed care plans, most of which are health maintenance organizations (HMOs) or competitive medical plans (CMPs). Both HMOs and CMPs contract with Medicare and follow the same contracting rules. In this handbook, HMOs will be used to illustrate the benefits for both.

Many beneficiaries find that coordinated care plans are a good way to get more health care for their dollar. HMOs provide or arrange for all Medicare covered services, and generally charge you fixed monthly premiums and only small copayments. This means that if you join a coordinated care plan and get all of your services through the HMO, your out-of-pocket costs are usually more predictable. Also, depending on your health needs, those costs may be less than you would pay if you were liable for the regular Medicare deductible and coinsurance amounts.

Coordinated care plans may also offer benefits not covered by Medicare for little or no additional cost. Benefits may include preventive care, dental care, hearing aids and eyeglasses.

Who Can Enroll in Coordinated Care Plans?

Most Medicare beneficiaries are eligible to enroll in HMOs. HMOs cannot screen their applicants to find whether they are healthy, or delay coverage for pre-existing conditions. The only enrollment criteria for Medicare HMOs are:

- You must be enrolled in Medicare Part B and continue to pay the Part B premiums (you do not need to be able to get Part A).
- You must live in the plan's service area.
- You cannot be receiving care in a Medicare-certified hospice.
- You cannot have permanent kidney failure.

If you develop permanent kidney failure or choose hospice coverage after joining a coordinated care plan, the plan will provide, pay for, or arrange for your care. If you choose to receive hospice care after joining a coordinated care plan, the plan must inform you about hospice services available in your area. Staff at the coordinated care plan will explain how the hospice choice affects your plan membership.

Joining a Coordinated Care Plan

To join a coordinated care plan, contact plans in your area that have a contract with Medicare. All HMOs have an advertised open enrollment period at least once a year. Once you join, you may stay with the plan as long as you wish. And you may return to regular Medicare at any time.

If you enroll in a coordinated care plan you will usually be required to get all care from the plan. In most cases, if you get services that are not authorized by the HMO (unless they are emergency services, or services you urgently need when you are out of the plan's service area) **neither the plan nor Medicare will pay for the services.**

When you join an HMO, be sure to read your membership materials carefully to learn your rights and coverage.

Ending Enrollment in a Coordinated Care Plan

To end your enrollment in a coordinated care plan, send a signed request to your plan or to your local Social Security or Railroad Retirement Board office. You return to regular Medicare the first day of the month following the month your request is received by one of these offices.

If You Have Problems

If you belong to a Medicare HMO and you are unhappy with the quality of care, you can:

- Follow your HMO's grievance procedure.
- Complain to your Peer Review Organization (PRO). PROs are groups of practicing doctors and other health care professionals under contract to Medicare to review the care provided to Medicare patients (see page 3).

If you believe that your HMO has made an incorrect decision on coverage of benefits or payment of a claim, you can exercise your appeal rights—rights that are similar to those provided under traditional Medicare. (See page 33 for more information about appeals.)

NOTE: A new Medicare supplement (Medigap) option is now available in some states. It is a kind of coordinated care plan called Medicare SELECT (see page 8 for more information).

If you need more information about Medicare and coordinated care plans, you can get a copy of *Medicare and Coordinated Care Plans* from the Consumer Information Center (see inside back cover).

Medicare and Other Insurance

Buying Health Insurance to Supplement Medicare (Medigap)

Medicare provides basic protection against the high cost of health care, but it will not pay all of your medical expenses, nor most long-term care expenses. For this reason, many private insurance companies sell insurance to supplement Medicare (Medigap insurance) as well as separate long-term care insurance. The federal government does not sell or service such insurance.

Shopping for Medigap Insurance

If you are thinking about buying a new private insurance policy or replacing an old policy to supplement your Medicare protection or cover long-term care costs, you should shop carefully. You can get a booklet, *Guide to Health Insurance for People with Medicare*, to help you make Medicare supplement decisions. (See box below for more information about the guide.)

New Open Enrollment Period for Medigap Policies

A new open enrollment period for selecting Medigap policies guarantees that for **six months immediately following enrollment in Medicare Part B**, people age 65 or older cannot be denied Medigap insurance or charged higher premiums because of health problems. Even if you buy a Medigap policy and switch to another within the six-month open enrollment period (you may switch as many times as you wish) you can still get the open enrollment guarantee. All Medigap policies becoming effective after November 5, 1991 are covered by this law.

No matter how you enroll in Part B—whether by automatic notification or through an initial, special or general enrollment period—you are covered by the new guarantees if both of the following are true:

- You are 65 or older and are enrolled in Medicare based on age rather than disability.
- The date you get by adding six months to the effective date for your Part B coverage (printed on your Medicare card) is in the future. The date you get tells you when your Medigap open enrollment ends.

NOTE: Even though you are guaranteed enrollment, your Medigap policy may not provide services for a preexisting condition until a six-month waiting period has passed.

New Standardized Medigap Policies

During 1992, most states will adopt regulations limiting the sale of Medigap insurance to no more than 10 standard policies. One of the 10 will be a basic policy offering a "core package" of benefits. The other nine will each have a different combination of benefits, but they will all include the core package. The basic policy, offering the core package of benefits, will be available in all states.

To find out when the new standardized policies will be available in your state, and how many of the 10 have been or are likely to be approved for sale, check with your state insurance department. The telephone number of your state insurance department is probably listed under "state agencies" in your telephone book. If not, you can get a copy of the *Guide to Health Insurance for People with Medicare* (see box below).

If you already have a Medigap policy, you may keep it. You do not have to switch to one of the new standard policies. But, if you buy a new policy, you will probably be required to choose from one of the new standard plans.

Medicare SELECT

A new kind of Medigap insurance is scheduled to be introduced in 15 states beginning in 1992. It is called Medicare SELECT. The difference between Medicare SELECT and standard Medigap insurance is that Medicare beneficiaries who buy a Medicare SELECT policy will be charged a lower premium in return for agreeing to use the services of certain designated health care profes-

You can order a free copy of the *Guide to Health Insurance for People With Medicare* from the Consumer Information Center. There is ordering information on the inside back cover of this book. The guide:

- Explains how supplemental insurance works.
- Tells how to shop for Medigap insurance.
- Gives information on the new standard plans.
- Gives information on Medicare SELECT.
- Lists names, addresses and telephone numbers of state insurance departments and state agencies on aging. Some of these offices may have free counseling services available.

sionals. These health care professionals, called "preferred providers," will be selected by the insurers.

Insurers, including some HMOs, offer Medicare SELECT in the same way standard Medigap insurance is offered. The policies are required to meet certain federal standards and are regulated by the states in which they are approved.

The states in which Medicare SELECT policies are expected to be available are Alabama, Arizona, California, Florida, Indiana, Kentucky, Michigan, Minnesota, Missouri, North Dakota, Ohio, Oregon, Texas, Washington and Wisconsin. If you live in one of these states, you can ask your state insurance department about the Medicare SELECT policies that have been approved for sale in the state.

Coordinated Care Plans Instead of Medigap

Coordinated care plans that contract with Medicare are not Medigap plans. But they can be an alternative to standard Medigap insurance. (See page 6 for more information about coordinated care plans.)

There are Rules for Selling Medigap Insurance

Both state and federal laws govern sales of Medigap insurance. Companies or agents selling Medigap insurance must avoid certain illegal practices. Federal criminal and civil penalties (fines) may be imposed against any insurance company or agent that knowingly:

- Sells you a policy that duplicates Medicare coverage, Medicaid coverage, or your private health insurance coverage.
- Tells you that they are employees or agents of the Medicare program or of any government agency.
- Makes a false statement that a policy meets legal standards for certification when it does not.
- Sells you a policy that is not one of the approved standard policies (after the new standards have been put in place in your state).
- Denies you your Medigap open enrollment period by refusing to issue you a policy, placing conditions on the policy, or discriminating in the price of a policy because of your health status, claims experience, receipt of health care, or your medical condition.
- Uses the U.S. mail in a state for advertising or delivering health insurance policies to supplement Medicare if the policies have not been approved for sale in that state.

If You Suspect Illegal Sales Practices

If you suspect that you have been the victim of illegal sales practices, you should report these practices to your state insurance department. States are responsible for the regulation of insurance policies issued within their boundaries. Since there are also federal laws governing Medigap sales practices, you should also report the p ractices to the appropriate federal officials.

Your state insurance department may be listed in your telephone book. If not, you can get a copy of the booklet, *Guide to Health Insurance for People with Medicare* (see box on page 8).

To talk to federal officials about the suspected illegal sales practices, you may call this number : 1-800-638-6833.

When Other Insurance Pays Before Medicare

If any of the following insurance situations applies to you, please notify your doctor, hospital, and all other providers of services.

When You or Your Spouse Continue To Work

Medicare has special rules that apply to beneficiaries who have employer group health plan coverage through their employment or the employment of a spouse.

Group health plans of employers with 20 or more employees are primary payers and Medicare is secondary payer for workers age 65 or over, and workers' spouses age 65 or over. Group health plans must offer these people the same health insurance benefits under the same conditions offered to younger workers and spouses. You and your spouse have the option to reject the plan offered by the employer. If you reject the employer's health plan, Medicare will remain the primary health insurance payer. In that case, the employer plan is not permitted to offer you coverage that supplements Medicare covered services. If your employer plan denies you coverage, offers you different coverage, or pays benefits that are secondary to Medicare, notify the carrier that handles your Medicare claims.

For more information, contact your employer or ask Social Security for a copy of *Medicare: Employer Health Plans*. The publication is also available from the Consumer Information Center (see inside back cover).

If You Are Disabled and Under Age 65

Medicare is the secondary payer for certain disabled people who have premium-free Medicare Part A and are covered under an employer's health plan or the employer health plan of an employed family member. This secondary payer provision applies to group health plans of employers that employ 100 or more people. Under certain conditions, the secondary payer provision also applies to group health plans of employers with fewer than 100 employees.

For more information, contact your employer or ask Social Security for a copy of *Medicare: Employer Health Plans*. The publication is also available from the Consumer Information Center (see inside back cover).

Other Situations Where Medicare is the Secondary Payer

If you have a work-related illness or injury, services provided as treatment of that illness or injury should be covered by workers' compensation or federal black lung benefits. It is important that your Medicare claim form note that the treatment is related to a work-related illness or injury, even if the injury or illness occurred in the past.

Medicare is a secondary payer during a period (generally 18 months) for beneficiaries who have Medicare solely on the basis of permanent kidney failure, if they have employer group health plan coverage themselves or through a family member.

Medicare also serves as the secondary payer in cases where no-fault insurance or liability insurance is available as the primary payer.

Although Medicare benefits are secondary to benefits paid by liability insurers, Medicare may make a **conditional** payment if it receives a claim for services covered by liability insurance. In those cases, Medicare may pay the claim; then, when a liability settlement is reached, Medicare recovers its conditional payment from the settlement amount.

If You Have or Can Get Both Medicare and Veterans Benefits

If you have or can get both Medicare and veterans benefits, you may choose to get treatment under either program. But, Medicare:

- Cannot pay for services you receive from Veterans Affairs (VA) hospitals or other VA facilities, except for certain emergency hospital services; and
- Generally cannot pay if the VA pays for VA-authorized services that you get in a non-VA hospital or from a non-VA physician.

Since July 1986, the VA has been charging coinsurance payments to some veterans who have non-service connected conditions for treatment in a VA hospital or medical facility, or for VA-authorized treatment by non-VA sources. The VA charges coinsurance payments when the veteran's income exceeds a particular level. If the VA charges you a coinsurance payment for **VA-authorized care by a non-VA physician or hospital**, Medicare may be able to reimburse you, in whole or in part, for your VA coinsurance payment obligation.

NOTE: Medicare cannot reimburse you for VA coinsurance payments for services furnished by VA hospitals and facilities, unless the services are emergency inpatient or outpatient **hospital** services. Then, the Medicare payment is subject to Medicare deductible and coinsurance amounts.

If you have questions about whether the VA or Medicare should pay for your doctor or other services covered under Medicare Part B, contact your Medicare carrier. If you have questions about whether the VA or Medicare should pay for hospital or other services covered under Medicare Part A, ask the provider of services to check with the Medicare intermediary.

The Data Match

In 1989, Congress passed a law that will help Medicare get back an estimated $1 billion in taxpayer money. The law will enable Medicare to get accurate information about beneficiaries' health insurance.

The law authorizes the Health Care Financing Administration (the agency that administers the Medicare program), the Internal Revenue Service, and the Social Security Administration to share information about whether Medicare beneficiaries or their spouses are working and whether they have employment-related health insurance.

The process for sharing information from other agencies is called the Data Match. The Data Match will help Medicare find cases where another insurer should have paid first on Medicare beneficiaries' health care claims. A designated Medicare contractor will contact employers to confirm health insurance coverage information. (For information about your rights under the data match, see page 5.)

What Medicare Does Not Pay For

Custodial Care

Medicare does not pay for custodial care when that is the **only** kind of care you need. Care is considered custodial when it is primarily for the purpose of helping you with daily living or meeting personal needs and could be provided safely and reasonably by people without professional skills or training. Much of the care provided in nursing homes to people with chronic, long-term illnesses or disabilities is considered custodial care. For example, custodial care includes help in walking, getting in and out of bed, bathing, dressing, eating, and taking medicine. Even if you are in a participating hospital or skilled nursing facility, Medicare does not cover your stay if you need only custodial care.

Care Not Reasonable and Necessary Under Medicare Program Standards

Medicare does not pay for services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury. These services include drugs or devices that have not been approved by the Food and Drug Administration (FDA); medical procedures and services performed using drugs or devices not approved by FDA;* and services, including drugs or devices, not considered safe and effective because they are experimental or investigational.

If a doctor admits you to a hospital or skilled nursing facility when the kind of care you need could be provided elsewhere (for example, at home or in an outpatient facility), your stay will not be considered reasonable and necessary, and Medicare will not pay for your stay. If you stay in a hospital or skilled nursing facility longer than you need to be there, Medicare payments will end when inpatient care is no longer reasonable and necessary.

If a doctor (or other practitioner) comes to treat you—or you visit him or her for treatment—more often than is medically necessary, Medicare will not pay for the "extra" visits. Medicare will not pay for more services than are reasonable and necessary for your treatment.

*Some services are not covered by Medicare even when FDA has approved them.

Medicare always bases decisions about what is reasonable and necessary on professional medical advice.

Services Medicare Does Not Pay For

Medicare, by law, cannot pay for certain services. These include services performed by immediate relatives or members of your household, and services paid for by another government program. If you have a question about whether Medicare pays for a particular service, ask your Medicare carrier. (See pages 36 to 41 for the name and telephone number of your carrier.)

Limitation of Liability

Under Medicare law you will not be held responsible for payment of the cost of certain health care services for which you were denied Medicare payment if you did not know or you could not reasonably be expected to know (that is, you had not received a written notice) that the services were not covered by Medicare. This provision is called limitation of liability and is often referred to as a "waiver of liability." This protection from financial liability applies only when the care was denied because it was one of the following:

- Custodial care.
- Not "reasonable and necessary" under Medicare program standards for diagnosis or treatment.
- For home health services, the patient was not homebound or not receiving skilled nursing care on an intermittent basis.

This limitation of liability provision does not apply to Medicare Part B services provided by a non-participating supplier who did not accept assignment of the claim.

This limitation of liability provision does not apply under most circumstances to Part B services furnished by a non-participating physician who did not accept assignment of the claim. However, in certain situations Medicare law will protect you from paying for services provided by a non-participating physician on a non-assigned basis that are denied as "not reasonable and necessary." If your physician knows or should know that Medicare will not pay for a particular service as "not reasonable and necessary," he or she must give you written notice—before performing the service—of the reasons why he or she believes Medicare will not pay. The physician must get your written agreement to pay for the services. If you did not receive this notice, you are not required to pay for the service. If you did pay, you may be entitled to a refund.

Medicare Hospital Insurance (Part A)

What Medicare Part A Includes

Medicare Part A helps pay for four kinds of medically necessary care:

1) Inpatient hospital care.
2) Inpatient care in a skilled nursing facility following a hospital stay.
3) Home health care.
4) Hospice care.

There is a limit on how many days of hospital or skilled nursing facility care Medicare helps pay for in each benefit period. But, your Part A protection is renewed every time you start a new benefit period. (Benefit periods are described below.)

Skilled nursing facility care is the only type of nursing home care that Medicare covers. **Medicare does not pay for care that is primarily custodial**. (See pages 11 and 15 for more about custodial care.)

Benefit Periods

A benefit period is a way of measuring your use of services under Medicare Part A. Your first benefit period starts the first time you enter a hospital after your hospital insurance begins. A benefit period ends when you have been out of a hospital or other facility primarily providing skilled nursing or rehabilitation services for 60 days in a row (including the day of discharge). If you remain in a facility (other than a hospital) that primarily provides skilled nursing or rehabilitation services, a benefit period ends when you have not received any skilled care there for 60 days in a row.

There is no limit to the number of benefit periods you can have for hospital and skilled nursing facility care. However, special limited benefit periods apply to hospice care (see page 17).

Here are two examples of how the benefit period works:

Example 1: Ms. Jones enters the hospital on January 5. She is discharged on January 15. She has used 10 days of her first benefit period. Ms. Jones is not hospitalized again until July 20. Since more than 60 days elapsed between her hospital stays, she begins a new benefit period, her Part A coverage is completely renewed, and she will again pay the hospital deductible. (The hospital deductible is explained on page 13.)

Example 2: Ms. Smith enters the hospital on August 14. She is discharged on August 24. She also has used 10 days of her first benefit period. However, she is then readmitted to the hospital on September 20. Since fewer than 60 days elapsed between hospital stays, Ms. Smith is still in her first benefit period and will not be required to pay another hospital deductible. This means that the first day of her second admission is counted as the eleventh day of hospital care in that benefit period. Ms. Smith will not begin a new benefit period until she has been out of the hospital (and has not received any skilled care in a skilled nursing facility) for 60 consecutive days.

How Medicare Pays for Part A Services

Medicare Part A helps pay for most but not all of the services you receive in a hospital or skilled nursing facility or from a home health agency or hospice program. There are covered services and noncovered services under each kind of care. Covered services are services and supplies that Part A pays for.

Hospitals, skilled nursing facilities, home health agencies and hospices are called "providers" under the Medicare Part A program. Providers submit their claims directly to Medicare—you cannot submit claims for their services. The provider will charge you for any part of the Part A deductible you have not met and any coinsurance payment you owe. Providers cannot require you to make a deposit before being admitted for inpatient care that is or may be covered under Part A of Medicare.

When a hospital, skilled nursing facility, home health agency, or hospice sends Medicare a Part A claim for payment, you get a Notice of Utilization that explains the decision Medicare made on the claim. **This notice is not a bill**. If you have any questions about the notice, get in touch with the people who sent you the notice.

When You Are a Hospital Inpatient

Medicare Part A helps pay for inpatient hospital care if **all** of the following four conditions are met:

1) A doctor prescribes inpatient hospital care for treatment of your illness or injury.
2) You require the kind of care that can be provided only in a hospital.

3) The hospital is participating in Medicare.*
4) The Utilization Review Committee of the hospital, a Peer Review Organization or an intermediary does not disapprove your stay.

If you meet these four conditions, Medicare will help pay for up to 90 days of medically necessary inpatient hospital care in each benefit period.**

During 1992, from the first day through the 60th day in a hospital during each benefit period, Part A pays for all covered services except the **first** $652. This is called the inpatient hospital deductible. (A deductible is an amount you owe before Medicare begins paying for services and supplies covered by the program.) **The hospital may charge you the deductible only for your first admission in each benefit period**. If you are discharged and then readmitted before the benefit period ends, you do not have to pay the deductible again.

From the 61st through the 90th day in a hospital during each benefit period, Part A pays for all covered services **except for $163 a day**. This daily amount is called coinsurance. The hospital charges you the $163.

Hospital reserve days (explained below) can help with your expenses if you need more than 90 days of inpatient hospital care in a benefit period.

Medicare Part A does not pay for the services of doctors and certain other practitioners, even though you receive these services in a hospital. Instead, those services are covered under Medicare Part B. (A description of Medicare Part B begins on page 19.)

Major services covered under Part A when you are a hospital inpatient:

- A semiprivate room (two to four beds in a room).
- All your meals, including special diets.
- Regular nursing services.
- Costs of special care units, such as intensive care or coronary care units.
- Drugs furnished by the hospital during your stay.
- Blood transfusions furnished by the hospital during your stay. (See page 14 for information about coverage of blood.)
- Lab tests included in your hospital bill.
- X-rays and other radiology services, including radiation therapy, billed by the hospital.
- Medical supplies such as casts, surgical dressings, and splints.
- Use of appliances, such as a wheelchair.
- Operating and recovery room costs.
- Rehabilitation services, such as physical therapy, occupational therapy, and speech pathology services.

Some services not covered under Part A when you are a hospital inpatient:

- Personal convenience items that you request such as a telephone or television in your room.
- Private duty nurses.
- Any extra charges for a private room unless it is determined to be medically necessary.

NOTE: If you disagree with a decision on the amount Medicare will pay on a claim or whether services you receive are covered by Medicare, you always have the right to appeal the decision (see page 32).

Hospital Inpatient Reserve Days

Medicare helps pay for your care in a hospital for up to 90 days in each benefit period. And Medicare Part A includes an extra 60 hospital days you can use if you have a long illness and have to stay in the hospital for more than 90 days. These extra days are called reserve days. **Once you use a reserve day you never get it back**. Reserve days are **not** renewable.

During 1992, Medicare Part A pays for all covered services **except $326 a day** for each reserve day you use. You are responsible for paying this $326.

You have only 60 reserve days in your lifetime, and you can decide when you want to use them. After you have been in the hospital 90 days, you can use all or some of your 60 reserve days if you wish. But you do not have to use your reserve days right away if you do not want to.

If you do not want to use your reserve days, you must tell the hospital in writing, either when you are admitted to the hospital, or at any time afterwards up to 90 days after you are discharged. If you use reserve days and then decide that you did not want to use them, you must request approval from the hospital to get them restored.

All Medigap plans pay some part of hospital bills after you have used all your reserve days. (See page 8 for more information about Medigap insurance.)

*Under certain conditions, Medicare helps pay for emergency inpatient care you receive in a non-participating hospital.

**Medicare pays for only limited inpatient care in a psychiatric hospital (see page14). The hospital can tell you about these limits.

Coverage of Blood Under Part A

Part A helps pay for blood (whole blood or units of packed red blood cells), blood components, and the cost of blood processing and administration. If you receive blood as an inpatient of a hospital or skilled nursing facility, Part A will pay for these blood costs, except for any nonreplacement fees charged for the first three pints of whole blood or units of packed red cells per calendar year. (The nonreplacement fee is the charge that some hospitals and skilled nursing facilities make for blood which is not replaced.)

You are responsible for the nonreplacement fees for the first three pints or units of blood furnished by a hospital or skilled nursing facility. If you are charged nonreplacement fees, you have the option of either paying the fees or having the blood replaced. If you choose to have the blood replaced, you can either replace the blood personally or arrange to have another person or an organization replace it for you. A hospital or skilled nursing facility cannot charge you for any of the first three pints of blood you replace or arrange to replace. (If you have already paid for or replaced blood under Medicare **Part B** during the calendar year, you do not have to meet those costs again under Medicare **Part A**. See page 19 for an explanation of coverage of blood under Medicare Part B.)

Care in a Psychiatric Hospital

Part A helps pay for no more than 190 days of inpatient care in a participating psychiatric hospital in your lifetime. Once you have used these 190 days, Part A does not pay for any more inpatient care in a psychiatric hospital.

Also, there is a special rule that applies if you are in a participating psychiatric hospital at the time your Part A starts. Social Security can give you more information.

Care Outside the United States

Medicare generally does not pay for hospital or medical services outside the United States. (Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands are considered part of the United States.)

If you are planning to travel outside the United States, you may want to buy special short-term health insurance for foreign travel. If you have other health insurance in addition to Medicare, check to see if health care in a foreign country is covered under your policy.

There are rare emergency cases where Medicare can pay for care in Canada or Mexico. Also, Medicare can sometimes pay if a Mexican or Canadian hospital is closer to your home than the nearest U.S. hospital that can provide the care you need. If you get emergency treatment in a Canadian or Mexican hospital or if you live near a Canadian or Mexican hospital, ask someone who works at the hospital about Medicare coverage, or have the hospital help you contact the Medicare intermediary.

Care in a Christian Science Sanatorium

Medicare Part A helps pay for inpatient hospital and skilled nursing facility services you receive in a participating Christian Science sanatorium if it is operated or listed and certified by the First Church of Christ, Scientist, in Boston. (However, Medicare Part B will not pay for the practitioner.)

The Prospective Payment System

Medicare pays for most inpatient hospital care under the Prospective Payment System (PPS). Under PPS, hospitals are paid a predetermined rate per discharge for inpatient services furnished to Medicare beneficiaries. The predetermined rates are based on payment categories called Diagnosis Related Groups, or DRGs. In some cases, the Medicare payment will be more than the hospital's costs; in other cases, the payment will be less than the hospital's costs. In special cases, where costs for necessary care are unusually high or the length of stay is unusually long, the hospital receives additional payment. **But even if Medicare pays the hospital less than the cost of your care, you do not have to make up the difference.**

It is important to remember that the PPS system does not change your Medicare Part A protection as described in this handbook. PPS does not determine the length of your stay in the hospital or the extent of care you receive. The law requires participating hospitals to accept Medicare payments as payment in full, and those hospitals are prohibited from billing the Medicare patient for anything other than the applicable deductible and coinsurance amounts, plus any amounts due for noncovered items or services, such as television, telephone or private duty nurses.

Skilled Nursing Facility Care

Medicare Part A can help pay for certain inpatient care in a Medicare-participating skilled nursing facility following a hospital stay. Your condition must require daily skilled nursing or skilled rehabilitation services which, as a practical matter, can only be provided in a skilled nursing facility, and the skilled care you receive must be based on a doctor's orders.

What is a Skilled Nursing Facility?

A skilled nursing facility is a specially qualified facility that specializes in skilled care. It has the staff and equipment to provide skilled nursing care or skilled rehabilitation services and other related health services. Skilled nursing care means care that can only be performed by, or under the supervision of, licensed nursing personnel. Skilled rehabilitation services may include such services as physical therapy performed by, or under the supervision of, a professional therapist.

Most nursing homes in the United States are **not** skilled nursing facilities that participate in Medicare. In some facilities, only certain portions participate in Medicare. If you are not sure whether a facility participates in Medicare as a skilled nursing facility, ask someone in the facility's business office. If staff at the facility cannot tell you, ask Social Security to check with the Health Care Financing Administration.

When Can Medicare Pay?

Medicare Part A can help pay for your care in a Medicare-participating skilled nursing facility if you meet **all of these six conditions**:

1) Your condition requires daily skilled nursing or skilled rehabilitation services which, as a practical matter, can only be provided in a skilled nursing facility.
2) You have been in a hospital at least three days in a row (not counting the day of discharge) before you are admitted to a participating skilled nursing facility.
3) You are admitted to the facility within a short time (generally within 30 days) after you leave the hospital.
4) Your care in the skilled nursing facility is for a condition that was treated in the hospital, or for a condition that arose while you were receiving care in the skilled nursing facility for a condition which was treated in the hospital.
5) A medical professional certifies that you need, and you receive, skilled nursing or skilled rehabilitation services on a daily basis.
6) The Medicare intermediary does not disapprove your stay.

All six conditions must be met. Remember, you must need skilled nursing care or skilled rehabilitation services on a daily basis. Part A will not pay for your stay if you need skilled nursing or rehabilitation services only occasionally, such as once or twice a week, or if you do not need to be in a skilled nursing facility to get skilled services. Also, Medicare will not pay for your stay if you are in a skilled nursing facility mainly because you need custodial care.

Skilled Care or Custodial Care?

The only type of "nursing home" care Medicare helps pay for is skilled nursing facility care. Medicare does not pay for custodial care when that is the only kind of care you need.

Care is considered custodial when it is primarily for the purpose of helping the patient with daily living or meeting personal needs, and could be provided safely and reasonably by people without professional skills or training. For example, custodial care includes help in walking, getting in and out of bed, bathing, dressing, eating and taking medicine.

When your stay in a skilled nursing facility is covered by Medicare, Part A helps pay for a maximum of 100 days in each benefit period, but only if you need daily skilled nursing care or rehabilitation services for that long.

If you leave a skilled nursing facility and are readmitted within 30 days, you do not have to have a new three day stay in the hospital for your care to be covered. If you have some of your 100 days left and you need skilled nursing or rehabilitation services on a daily basis for further treatment of a condition treated during your previous stay in the facility, Medicare will help pay.

In each benefit period, Part A pays for all covered services for the first 20 days you are in a skilled nursing facility. During 1992, for the 21st through the 100th day, Part A pays for all covered services except for $81.50 a day. You may be charged up to this daily coinsurance amount by the skilled nursing facility.

Medicare Part A does not cover your doctor's services while you are in a skilled nursing facility. Medicare Part B covers doctors' services. (A description of Medicare Part B begins on page 19.)

Major services covered under Part A when you are in a skilled nursing facility:

- A semiprivate room (two to four beds in a room).
- All your meals, including special diets.
- Regular nursing services.
- Physical, occupational, and speech therapy.
- Drugs furnished by the facility during your stay.
- Blood transfusions furnished during your stay. (See page 14 for information about coverage of blood.)
- Medical supplies such as splints and casts furnished by the facility.
- Use of appliances such as a wheelchair furnished by the facility.

Some services not covered under Part Awhen you are in a skilled nursing facility:

- Personal convenience items that you request such as a television in your room.
- Private duty nurses.
- Any extra charges for a private room, unless it is determined to be medically necessary.

NOTE: If you want to complain about a skilled nursing facility's treatment of patients or other conditions that concern you, you can contact the state survey agency. Each skilled nursing facility can give you the telephone number and address of the state survey agency if you ask for it. You can also look at a copy of the skilled nursing facility's latest certification survey report. The survey report will tell you the results of the state survey agency's review of how well the agency thinks the facility followed the rules about patient's rights, safety and quality of care. Also, if you disagree with a decision on the amount Medicare will pay on a claim or whether services you receive are covered by Medicare, you always have the right to appeal the decision (see page 32).

Home Health Care

If you need skilled health care in your home for the treatment of an illness or injury, Medicare pays for covered home health services furnished by a participating home health agency. A home health agency is a public or private agency that specializes in giving skilled nursing services and other therapeutic services, such as physical therapy in your home. (A hospital or other facility that mainly provides skilled nursing or rehabilitation services cannot be considered your home.)

Medicare pays for home health visits only if **all four** of the following conditions are met:

1) The care you need includes intermittent skilled nursing care, physical therapy, or speech therapy.
2) You are confined to your home (homebound).
3) You are under the care of a physician who determines you need home health care and sets up a home health plan for you.
4) The home health agency providing services is participating in Medicare.

Once all four of these conditions are met, either Medicare Part A or Medicare Part B will pay for all medically necessary home health services. When you no longer need intermittent skilled nursing care, physical therapy, or speech therapy, Medicare will pay for home health services if you continue to need occupational therapy.

Medicare home health services do not include coverage for general household services such as laundry, meal preparation, shopping, or other home care services furnished mainly to assist people in meeting personal, family, or domestic needs.

To determine whether you can get services under the Medicare home health benefit, ask your physician to refer you to a Medicare participating home health agency. The home health agency will evaluate your case to advise you about whether you meet the requirements for Medicare coverage. Home health agencies do not charge for this evaluation.

Home health services covered by Medicare:

- Part-time or intermittent skilled nursing care. (This can include eight hours of reasonable and necessary care per day for up to 21 consecutive days—or longer in certain circumstances.)
- Physical therapy.
- Speech therapy.

If you need intermittent skilled nursing care, or physical or speech therapy, Medicare also pays for:

- Occupational therapy.
- Part-time or intermittent services of home health aides.
- Medical social services.
- Medical supplies.
- Durable medical equipment (80 percent of approved amount).

Home health services not covered by Medicare:

- 24-hour-a-day nursing care at home.
- Drugs and biologicals.
- Meals delivered to your home.
- Homemaker services.
- Blood transfusions.

Medicare pays the full approved cost of all covered home health visits. You may be charged only for any services or costs that Medicare does not cover. However, if you need durable medical equipment, you are responsible for a 20 percent coinsurance payment for the equipment.

The home health agency will submit the claim for payment. You do not have to send in any bills yourself.

NOTE: If you disagree with a decision on the amount Medicare will pay on a claim or whether services you receive are covered by Medicare, you always have the right to appeal the decision (see page 32).

Hospice Care

A hospice is a public agency or private organization that is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people.

Hospice care is a special type of care for people who are terminally ill. It includes both home care and inpatient care, when needed, and a variety of services not otherwise covered under Medicare. Under the Medicare hospice benefit, Medicare pays for services every day and also permits a hospice to provide appropriate custodial care, including homemaker services and counseling.

Medicare Part A helps pay for hospice care if **all three** of these conditions are met:

1) A doctor certifies that the patient is terminally ill.
2) The patient chooses to receive care from a hospice instead of standard Medicare benefits for the terminal illness.
3) Care is provided by a Medicare-participating hospice program.

Special benefit periods apply to hospice care. Part A pays for two 90-day periods, followed by a 30-day period, and—when necessary—an extension period of indefinite duration. Hospice benefit periods may be consecutive. If a beneficiary cancels hospice care during one of the first three benefit periods, any days left in that period are lost, but the remaining benefit period(s) are still available. And, a beneficiary may disenroll from the hospice during any benefit period, return to regular Medicare coverage, then later re-elect the hospice benefit if another benefit period is available.

Two Benefit Period Examples:

- Mr. Jones cancelled his hospice care at the end of 59 days during his first 90-day benefit period. He lost the 31 remaining days of the first 90-day period. But if he wants to, he can choose hospice care again. He still has a 90-day period, a 30-day period, and the indefinite extension period.
- Ms. Smith cancelled hospice care during her final extension period. She cannot use the Medicare hospice benefit again.

There are no deductibles under the hospice benefit. The beneficiary does not pay for Medicare-covered services for the terminal illness, except for small coinsurance amounts for outpatient drugs and inpatient respite care.

The patient is responsible for five percent of the cost of outpatient drugs or $5 toward each prescription, whichever is less. For inpatient respite care, the patient pays five percent of the Medicare-allowed rate (approximately $4.53 per day in 1992). The rate varies slightly depending on the area of the country.

Respite care under the hospice program is a short-term inpatient stay in a facility. The Medicare beneficiary's inpatient stay gives temporary relief—a respite—to the person who regularly assists with home care. Each inpatient respite care stay is limited to no more than five days in a row.

While receiving hospice care, if a patient requires treatment for a condition not related to the terminal illness, Medicare continues to help pay for all necessary covered services under the standard Medicare benefit program.

Services covered by Part A when provided by a hospice:

- Nursing services.
- Doctors' services.
- Drugs, including outpatient drugs for pain relief and symptom management.
- Physical therapy, occupational therapy and speech-language pathology.
- Home health aide and homemaker services.
- Medical social services.
- Medical supplies and appliances.
- Short-term inpatient care, including respite care.
- Counseling.

The Medicare Part A hospice benefit **does not** pay for treatments other than for pain relief and symptom management of a terminal illness. Regular Medicare can usually help pay for treatments not related to the terminal illness.

NOTE: If you disagree with a decision on the amount Medicare will pay on a claim or whether services you receive are covered by Medicare, you always have the right to appeal the decision (see page 32).

Medicare Medical Insurance (Part B)

What Medicare Part B Includes

Medicare Part B helps pay for:

- Doctors' services.
- Outpatient hospital care.
- Diagnostic tests.
- Durable medical equipment.
- Ambulance services.
- Many other health services and supplies which are not covered by Medicare Part A.

The following sections tell you more about these different kinds of care, the services that are and are not covered by Medicare Part B, and what part of your medical expenses Medicare will pay.

Deductible and Coinsurance Amounts Under Part B

The Annual Deductible

You must pay the first $100 in approved charges for covered medical expenses in 1992. This is called the Medicare Part B annual deductible. You need to meet this $100 deductible only once during the year, and the deductible can be met by any combination of covered expenses. You do not have to meet a separate deductible for each different kind of covered service you receive.

The Blood Deductible

You must pay any nonreplacement fees charged for the first three pints or units of blood and blood components you use each year. (The nonreplacement fee is the charge that some practitioners and facilities make for blood which is not replaced.) This is called the Medicare Part B blood deductible. After you have replaced or paid for the first three pints of blood **and** you have met the $100 annual deductible, Medicare will pay 80 percent of the approved amount for blood, starting with the fourth pint. (If you have already paid for or replaced some units of blood under Medicare **Part A** during the calendar year, you do not have to pay for or replace that number of units again under Medicare **Part B**.)

Coinsurance

After you pay the annual deductible, you will owe a share of the Medicare-approved amount for most services and supplies. This share is called coinsurance. Usually, your coinsurance share is 20 percent of the Medicare-approved amount.

Medicare determines the approved amount for each service you receive. If your services were provided "**on assignment**," you pay only the coinsurance (see page 26 for an explanation of assignment).

If your services were **not provided "on assignment,"** and the charges for your services were more than the Medicare-approved amount, you usually owe the Medicare coinsurance plus certain charges above the Medicare-approved amount. (See "Medicare Approved Amounts" on page 27.) There are limits on the amount your doctor can charge you.

NOTE: This explanation of your deductible and coinsurance amounts describes Medicare's payment system for most services covered by Medicare Part B. In cases where payment for services is handled in a different way, you will be given an explanation along with the description of services covered. (You will find more information about how Medicare pays Part B claims in the next chapter.)

Doctors' Services Covered By Medicare Part B

Medicare Part B helps pay for covered services you receive from your doctor in his or her office, in a hospital, in a skilled nursing facility, in your home, or any other location.

Major doctors' services covered by Medicare Part B:

- Medical and surgical services, including anesthesia.
- Diagnostic tests and procedures that are part of your treatment.
- Radiology and pathology services by doctors while you are a hospital inpatient or outpatient.
- Treatment of mental illness. (Medicare payments for nonhospital treatment are limited; see page 25.)
- Other services such as:
  - —X-rays.
  - —Services of your doctor's office nurse.
  - —Drugs and biologicals that cannot be self-administered.
  - —Transfusions of blood and blood components.
  - —Medical supplies.
  - —Physical/occupational therapy and speech pathology services.

Some doctors' services not covered by Medicare Part B:

- Routine physical examinations, and tests directly related to such examinations (except some Pap smears and mammograms).
- Most routine foot care and dental care.
- Examinations for prescribing or fitting eyeglasses or hearing aids.
- Immunizations (except pneumococcal pneumonia vaccinations or immunizations required because of an injury or immediate risk of infection, and hepatitis B for certain persons at risk).
- Cosmetic surgery, unless it is needed because of accidental injury or to improve the function of a malformed part of the body.

Types of Doctors

Most doctors' services are furnished by a doctor of medicine or a doctor of osteopathy . Other "physicians" that can furnish some covered services include chiropractors, doctors of podiatric medicine (podiatrists), doctors of dental surgery or of dental medicine (dentists), and doctors of optometry (optometrists).

Chiropractors' Services

Medicare helps pay for only one kind of treatment furnished by a licensed chiropractor: manual manipulation of the spine to correct a subluxation that is demonstrated by X-ray. Medicare Part B does not pay for any other diagnostic or therapeutic services, including X-rays, furnished by a chiropractor.

Podiatrists' Services

Medicare Part B helps pay for any covered services of a licensed podiatrist to treat injuries and diseases of the foot. Examples of common problems include ingrown toenails, hammer toe deformities, bunion deformities and heel spurs.

Medicare generally does not pay for routine foot care such as cutting or removal of corns and calluses, trimming of nails, and other hygienic care. But, Medicare does help pay for some routine foot care if you are being treated by a medical doctor for a medical condition affecting your legs or feet (such as diabetes or peripheral vascular disease) which requires that the routine care be performed by a podiatrist or by a doctor of medicine or osteopathy.

Dentists' Services

Medicare Part B generally does **not** pay for care in connection with the treatment, filling, removal, or replacement of teeth; root canal therapy; surgery for impacted teeth; or other surgical procedures involving the teeth or structures directly supporting the teeth. However, Medicare **does** help pay for services of a dentist in certain cases when the medical problem is more extensive than the teeth or structures directly supporting them. (If you need to be hospitalized because of the severity of a dental procedure, Medicare Part A will pay for your **inpatient** hospital stay even if the dental care itself is not covered by Medicare.)

Optometrists' Services

Medicare helps pay for Medicare-covered vision care, including the services of an optometrist if the optometrist is legally authorized to perform those services by the state in which he or she performs them. However, Medicare will not pay for routine eye exams, and it will usually not pay for eyeglasses. (Medicare will pay for cataract spectacles, cataract contact lenses, or intraocular lenses that replace the natural lens of the eye after cataract surgery. Medicare will also pay for one pair of conventional eyeglasses or conventional contact lenses if necessary after insertion of an intraocular lens.)

Second Opinion Before Surgery

Sometimes your doctor may recommend surgery for the treatment of a medical problem. In some cases, surgery is unavoidable. But there is increasing evidence that many conditions can be treated equally well without surgery. Because even minor surgery involves some risk, we recommend that you get an opinion from a second doctor to help you decide about surgery. Medicare will help pay for a second opinion. Medicare will also help pay for a third opinion if the first and second opinions contradict each other.

Your own doctor is the best source for referral to another doctor. But, if you wish, you can call your Medicare Part B carrier for the names and phone numbers of doctors in your area who provide second opinions. (Medicare carriers are listed on pages 36 to 41.)

Services of Special Practitioners

Medicare Part B helps pay for covered services you receive from certain specially qualified practitioners who are not physicians. The practitioners must be approved by Medicare. Medicare-approved practitioners are listed below:

- Certified registered nurse anesthetist.
- Certified nurse midwife.
- Clinical psychologist.
- Clinical social worker (other than in a hospital or skilled nursing facility).
- Physician assistant. (A physician assistant can furnish certain services in a hospital or certain other facilities; can serve as an assistant-at-surgery; and can furnish services in any location that is designated as a rural health professional shortage area.)
- Nurse practitioner and clinical nurse specialist in collaboration with a physician. (A nurse practitioner can furnish services in a skilled nursing facility or a Medicaid nursing facility in any area. In addition, a nurse practitioner or clinical nurse specialist can furnish services in a rural area.)

Outpatient Hospital Services

Medicare Part B helps pay for covered services you receive as an outpatient from a participating hospital for diagnosis or treatment of an illness or injury. Under certain conditions, Medicare helps pay for emergency outpatient care you receive from a non-participating hospital.

When you get outpatient hospital services, you are responsible for the annual Medicare Part B deductible. In addition to the deductible, you are responsible for a coinsurance of 20 percent of the hospital's charge above the deductible.

When you go to a hospital for outpatient services, you are sometimes asked how much of your Part B deductible you have met. One easy way to answer that question is to show your most recent *Explanation of Your Medicare Part B Benefits* notice. From this form, hospital staff can usually tell how much of the $100 annual deductible you have met.

If the hospital cannot tell how much of the $100 deductible you have met and the charge for the services you received is less than $100, the hospital may ask you to pay the entire bill. The amount you pay the hospital can be credited toward any part of the deductible you have not met. If you pay the hospital for deductible amounts you do not owe, the hospital or the Medicare intermediary will refund the amount you overpaid.

Major outpatient hospital services covered by Part B:

- Services in an emergency room or outpatient clinic, including same-day surgery.
- Laboratory tests billed by the hospital.
- Mental health care in a partial hospitalization psychiatric program, if a physician certifies that inpatient treatment would be required without it.
- X-rays and other radiology services billed by the hospital.
- Medical supplies such as splints and casts.
- Drugs and biologicals that cannot be self-administered.
- Blood transfusions furnished to you as an outpatient.

Some outpatient hospital services not covered by Part B:

- Routine physical examinations, and tests directly related to such examinations (except some Pap smears and mammograms).
- Eye or ear examinations to prescribe or fit eyeglasses or hearing aids.
- Immunizations, (except pneumococcal pneumonia and hepatitis B vaccinations, or immunizations required because of an injury or immediate risk of infection).
- Most routine foot care.

Other Services and Supplies Covered by Medicare

Ambulatory Surgical Services

An ambulatory surgical center is a facility that provides surgical services that do not require a hospital stay. Medicare Part B will pay for the use of an ambulatory surgical center for certain approved surgical procedures. However, by law Medicare can only pay centers that have an agreement with Medicare to participate in the Medicare program. If you do not know whether an ambulatory surgical center participates in Medicare, ask someone in the center's business office. If that person does not know, contact Social Security and ask them to check with the Health Care Financing Administration.

In addition to helping pay for the use of the ambulatory surgical center, Medicare also helps pay for physician

and anesthesia services that are provided in connection with the procedure.

Home Health Services

If you have both Medicare Part A and Part B, your Part A pays for home health services. But Part B will pay for home health services if you do not have Part A. Medicare home health services are described on page 16.

Outpatient Physical and OccupationalTherapy and Speech Pathology Services

Medicare Part B helps pay for medically necessary outpatient physical and occupational therapy or speech pathology services, if **all** the following three conditions are met:

1) Your doctor prescribes the service.
2) Your doctor or therapist sets up the plan of treatment.
3) Your doctor periodically reviews that plan.

You can receive physical therapy, occupational therapy or speech pathology services as an outpatient of a participating hospital or skilled nursing facility, or from a participating home health agency, rehabilitation agency, or public health agency. The provider of services may charge you only for any part of the $100 annual deductible you have not met, 20 percent of the remaining approved amount, and any noncovered services.

Also, you can receive services directly from an independently practicing, Medicare-approved physical or occupational therapist in his or her office or in your home if such treatment is prescribed by a doctor. But, the maximum amount Medicare pays for each of these services provided by an independently practicing physical or occupational therapist in 1992 is $600 a year. (This is 80 percent of the maximum approved amount of up to $750.) The Medicare payment would be less than $600 if charges for these services are used to meet part or all of your $100 annual deductible.

Comprehensive Outpatient Rehabilitation Facility Services

Under certain circumstances, Medicare helps pay for outpatient services you receive from a Medicare-participating comprehensive outpatient rehabilitation facility (CORF). Covered services include physicians' services; physical, speech, occupational and respiratory therapies; counseling; and other related services. You must be referred by a physician who certifies that you need skilled rehabilitation services. For most CORF services, you are responsible only for the annual deductible and 20 percent of the Medicare approved-charges. Medicare helps pay for mental health treatment in a CORF; the Medicare payment limit for mental health treatment in a CORF is discussed on page 25.

Partial Hospitalization for Mental Health Treatment

Partial hospitalization means an ambulatory program of active care that lasts less than 24 hours a day. Under certain conditions, Medicare Part B helps pay for partial hospitalization for mental health services furnished by hospital outpatient units and by qualified community mental health centers. If you are considering mental health treatment, check with the program you have chosen to see if it meets the conditions for Medicare payment.

Rural Health Clinic Services

Medicare Part B helps pay for services of physicians, nurse practitioners, physician assistants, nurse midwives, visiting nurses (under certain conditions), clinical psychologists, and clinical social workers furnished by a rural health clinic. You are responsible only for the annual Medicare Part B deductible plus 20 percent of the Medicare-approved charge for the clinic.

Federally Qualified Health Center Services

Federally qualified health centers are located in both rural and urban areas. As part of the "federally qualified health center benefit," Medicare Part B helps pay for services of physicians, nurse practitioners, physician assistants, nurse midwives, visiting nurses (under certain conditions), clinical psychologists, and clinical social workers. Also, as part of the federally qualified health center benefit, Medicare helps pay for certain preventive health services. You do **not** have to pay the Medicare Part B annual deductible for services provided under the federally qualified health center benefit. You **are** responsible for 20 percent of the Medicare-approved charge for the clinic.

There are some specialized services that may be provided by a federally qualified health center that are **not** part of the federally qualified health center benefit. For these services, you **do** have to meet the annual Part B deductible. As long as the center meets Medicare

requirements to provide these specialized services, Medicare Part B can help pay for them. The center will tell you if the service you need is a specialized service. For example, your center may provide screening mammograms. If you get a mammogram at the center, you are responsible for any unmet part of the annual Medicare Part B deductible plus 20 percent of the Medicare-approved charge for the mammogram.

Independent Laboratory Services

Medicare Part B pays the full approved fee for covered clinical diagnostic tests provided by independent laboratories that are approved to perform them. The laboratory must accept assignment for these tests. (See page 26 for an explanation of assignment.) It may not bill you for the tests.

Not all laboratories are approved by Medicare and some laboratories are approved only for certain kinds of tests. If a doctor orders tests which the laboratory is not approved to perform, Medicare does not pay for the tests, and you can be required to pay for them. Your doctor can usually tell you which laboratories are approved and whether the tests he or she is ordering from an approved laboratory are covered by Medicare. If your doctor can not tell you, call your Part B carrier. (Carriers are listed on pages 36 to 41.)

Your doctor must accept assignment for covered clinical diagnostic laboratory tests which he or she furnishes. Your doctor is not allowed to bill you for the tests. (See page 26 for an explanation of assignment.)

Portable Diagnostic X-ray Services

Medicare Part B helps pay for portable diagnostic X-ray services you receive in your home or other locations if they are ordered by a doctor and if they are provided by a Medicare-approved supplier. You can ask your Part B carrier whether the supplier is Medicare-approved. (Carriers are listed on pages 36 to 41.)

Other Diagnostic Tests

Medicare Part B also helps pay for other diagnostic tests, including X-rays, that your doctor orders to evaluate your medical problems.

Pap Smear Screening

Medicare Part B helps pay once every three years for Pap smears to screen for cervical cancer. Medicare helps pay more frequently for certain women at high risk. Medicare also pays for diagnostic Pap smears as needed when symptoms are present.

Breast-Cancer Screening (Mammography)

Medicare Part B helps pay for X-ray screenings for the detection of breast cancer, if they are provided by a Medicare-approved supplier. Women 65 or older can use the benefit every other year. Younger, disabled women covered by Medicare can use the screening benefit more frequently. Medicare also pays for diagnostic mammograms as needed when symptoms are present.

For accurate up-to-date information on cancer prevention, detection, diagnosis, and treatment for patients, their families, and the general public, call the Cancer Information Service at 1-800-4-CANCER.

Radiation Therapy

Medicare Part B helps pay for outpatient radiation therapy given under the supervision of your doctor.

Kidney Dialysis and Transplants

Medicare Part B helps pay for kidney dialysis and transplants. For detailed information on this coverage, you can get a copy of *Medicare Coverage of Kidney Dialysis and Kidney Transplant Services* from the Consumer Information Center (see inside back cover).

Heart and Liver Transplants

Under certain limited conditions, Medicare Part B helps pay for heart and liver transplants in a Medicare-approved facility. If you are considering a heart or liver transplant, you and your physician can find out about Medicare coverage by contacting your Medicare carrier. If you belong to an HMO, the HMO will give you the information you need about Medicare coverage.

Ambulance Transportation

Medicare Part B helps pay for medically necessary ambulance transportation, but only if:

- The ambulance, equipment and personnel meet Medicare requirements.
- Transportation in any other vehicle could endanger your health.

Under these conditions, Medicare helps pay for ambulance transportation but only to a hospital or skilled nursing facility, or from a hospital or skilled nursing facility to your home. Medicare does **not** pay for ambulance use from your home to a doctor's office or to a dialysis facility.

Medicare usually helps pay only if the ambulance transportation is in your local area. But, if there are no local facilities equipped to provide the care you need, Medicare helps pay for necessary ambulance transportation to the closest facility outside your local area that can provide the necessary care. If there is a local facility equipped to provide the care you need but you choose to go to another institution that is farther away, Medicare payment is based on the charge for transportation to the closest facility that can provide the necessary care.

Durable Medical Equipment

Medicare Part B helps pay for durable medical equipment such as oxygen equipment, wheelchairs, and other medically necessary equipment that your doctor prescribes for use in your home. (A hospital or facility that mainly provides skilled nursing or rehabilitation services cannot be considered your home.)

To be considered durable medical equipment, the equipment must be able to be used over again by other patients, must primarily serve a medical purpose, must not be useful to people who are not sick or injured, and must be appropriate for use in your home. Not all types of equipment that you might find useful can meet all four of these requirements.

Only your own doctor should prescribe medical equipment for you. An equipment supplier should not take any of the following actions:

- Contact you first, either by phone or by mail, and offer to get your doctor or Medicare to approve an item. (It is all right for the supplier to contact you in response to calls from your doctor or other health care workers.)
- Say he or she works for, or represents, Medicare.
- Deliver equipment to your home that neither you nor your doctor ordered.
- Send you used items, while billing Medicare for new ones.

Some of these actions may be against the law. If you believe a supplier has taken any of these actions, you should alert Medicare. First, ask your doctor whether he or she ordered the item. If your doctor did not order the item, you should file a complaint with your Medicare carrier. You can file a complaint by phone, in person or in writing. Your carrier will investigate.

It is also illegal for a supplier to offer you items at no cost to you or offer to pay the Medicare coinsurance on items. If a supplier makes one of these offers, file a complaint with your Medicare carrier as described above.

NOTE: The durable medical equipment supplier must have your doctor's prescription before delivering any of the following items: seat lift chairs, power-operated vehicles, equipment for care of pressure sores, or transcutaneous electrical nerve stimulators. **In the case of seat lift chairs, Medicare covers only the lift mechanism, not the chair itself.**

Medicare uses three methods of payment for durable medical equipment: lease-purchase, lump-sum payment for purchase, or rental charges. Your Medicare carrier will be able to provide more specific guidance on which method will be used for a particular item. (Carriers are listed on pages 36 to 41.)

Prosthetic Devices

Medicare Part B helps pay for prosthetic devices needed to substitute for an internal body organ. These include Medicare-approved corrective lenses needed after a cataract operation, ostomy bags and certain related supplies, and breast prostheses (including a surgical brassiere) after a mastectomy. Medicare also helps pay for artificial limbs and eyes, and for arm, leg, back, and neck braces. Medicare does **not** pay for orthopedic shoes unless they are an integral part of leg braces **and** the cost is included in the charge for the braces. Medicare does **not** pay for dental plates or other dental devices.

Medical Supplies

Medicare Part B helps pay for surgical dressings, splints, and casts ordered by a doctor in connection with your medical treatment. This does not include adhesive tape, antiseptics, or other common first-aid supplies.

Drugs and Biologicals

Pneumococcal Pneumonia Vaccine

Medicare Part B pays the full approved charges for pneumococcal pneumonia vaccine and its administration. Neither the $100 annual deductible nor the 20 percent coinsurance applies to this service.

Hepatitis B Vaccine

Medicare Part B helps pay for hepatitis B vaccine administered to beneficiaries considered to be at high or intermediate risk of contracting the disease.

Hemophilia Clotting Factors

Medicare Part B helps pay for blood clotting factors and items related to their administration for hemophilia patients who are able to use them to control bleeding without medical or other supervision. The amount of clotting factors necessary to have on hand for a specific period is determined for each patient individually.

Blood

Medicare Part B helps pay for blood and blood components you receive as a hospital outpatient or as part of other services. (See page 19 for an explanation of the blood deductible.)

Antigens

Under certain circumstances, Medicare Part B helps pay for antigens prepared for you by your doctor. You can check with your Medicare carrier to see if Medicare will pay for your antigens. (Carriers are listed on pages 36 to 41.)

Immunosuppressive Drugs

Immunosuppressive drugs are often given to prevent rejection of transplanted organs. Medicare Part B helps pay for drugs used in immunosuppressive therapy for one year beginning with the date of discharge from the inpatient hospital stay during which a Medicare-covered organ transplant was performed.

Epogen

Medicare Part B helps pay for the drug epogen (EPO) when used to treat Medicare beneficiaries with anemia related to chronic kidney failure, or with AIDS. (The kidney failure patients are not required to be on dialysis.) The EPO must be administered incident to the services of a doctor in the office or in a hospital outpatient department. Part B also helps pay for EPO that is self-administered by home dialysis patients or administered by their caregivers.

Medicare Payments for Nonhospital Treatment of Mental Illness

Medicare helps pay for services you receive for nonhospital treatment of a mental illness. You may get the services from doctors, comprehensive outpatient rehabilitation facilities (CORFs), physician assistants, psychologists and clinical social workers.

These services for nonhospital treatment of a mental illness are subject to a **special payment rule**. In effect, once the annual deductible is met, Medicare Part B pays only 50 percent (not 80 percent) of approved charges for these services. On assigned claims, beneficiaries are responsible for paying the remaining 50 percent. For unassigned claims, beneficiaries may have to pay more. (See page 26 for information about assignment.)

Partial hospitalization services for treatment of mental illness are not subject to this special payment rule. Also, brief office visits for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental illness are not subject to this special payment rule. (See page 22 for more information about partial hospitalization services.)

Medicare Medical Insurance (Part B) Payments

The Assignment Payment Method

Under the assignment method, your doctor or supplier agrees to accept the amount approved by the Medicare carrier as total payment for covered services: the doctor or supplier agrees to "take assignment."

The assignment method can save you money. The doctor or supplier sends the claim to Medicare. Medicare pays your doctor or supplier 80 percent of the Medicare-approved amount, after subtracting any part of the $100 annual deductible you have not met. The doctor or supplier can charge you only for the part of the $100 annual deductible you have not met and for the coinsurance, which is the remaining 20 percent of the approved amount. Of course, your doctor or supplier also can charge you for services that Medicare does not cover.

Doctors and certain other practitioners and suppliers must take assignment on all claims for services furnished to Medicare beneficiaries who are eligible for medical assistance through their state Medicaid program, including Qualified Medicare Beneficiaries. (See 'Assistance for Low-Income Beneficiaries,' page 4.)

Participating Doctors and Suppliers

Doctors and suppliers may sign agreements to become **Medicare participating**. Medicare-participating doctors and suppliers have agreed in advance to accept assignment on all Medicare claims. Doctors and suppliers are given the opportunity to sign participation agreements each year. Medicare-participating doctors and suppliers can display emblems or certificates which show that they accept assignment on all Medicare claims.

The names and addresses of Medicare-participating doctors and suppliers are listed (by geographic area) in the *Medicare-Participating Physician/Supplier Directory*. You can get the directory for your area free of charge from your Medicare carrier (see pages 36 to 41); or you can call your carrier and ask for names of some participating doctors and suppliers in your area. Also, this directory is available for you to look at in Social Security offices, state and area offices of the Administration on Aging, and in most hospitals.

When Your Doctor Does Not Accept Assignment

If your doctor or supplier does not accept assignment, you must pay the doctor or supplier directly. You are responsible for the part of your bill that is more than the Medicare-approved amount—up to the limit explained below. You pay this amount because your doctor or supplier did not agree to accept the Medicare-approved amount as payment in full. In this case, Medicare pays you 80 percent of the approved amount, after subtracting any part of the $100 annual deductible you have not met.

Even though a doctor does not accept assignment, there are limits on the amount that he or she can actually charge you. In 1992, the most the doctor can charge you is 120 percent of the fee schedule amount for non-participating physicians. (The fee schedule is explained under "Medicare Approved Amounts," page 27.) Doctors who charge more than these limits may be fined. If you think you have been charged more than the acceptable level, please call or write the carrier.

Special rule for doctors performing elective surgery: In addition to the limit on charges, Medicare law requires doctors who do not take assignment for elective surgery to give you a written estimate of your costs before the surgery if the total charge for the surgical procedure is $500 or more. If the doctor did not give you a written estimate, you are entitled to a refund of any amount you paid him or her over the Medicare-approved amount.

Many doctors and suppliers who do not take assignment on all claims may take assignment on some or most claims. Ask your doctor or supplier whether he or she will take assignment on your claims.

Examples of two payments for the same service are shown on page 27. Dr. A accepts assignment. Dr. B does not accept assignment. In both examples, the beneficiary has already met the $100 deductible.

Participating Providers

Hospitals, skilled nursing facilities, home health agencies, hospices, comprehensive outpatient rehabilitation facilities, and providers of outpatient physical and occupational therapy and speech pathology services are all participating providers under Medicare Part B. They

Two Payment Examples

The Annual Part B Deductible has been met

	Actual Amount	Medicare Approved Amount	Medicare Pays	Beneficiary Responsible For
Doctor A Accepts Assignment	$480	$400	$320 (80% of approved amount)	$80 (20% of approved amount)
Doctor B Does Not Accept Assignment*	$480	$400	$320 (80% of approved amount)	$160 (difference between actual charge and Medicare payment)

*There are certain limits on the charges of doctors who do not accept assignment; and there is a special rule for doctors performing elective surgery (see page 26).

submit their claims to Medicare and must accept the Medicare-approved amount as payment in full for covered services. Medicare subtracts any deductible you have not met and any coinsurance amount and pays the provider. The provider then bills you for only those deductible and coinsurance amounts.

Medicare Approved Amounts

Medicare Part B payments are based for the most part on Medicare fee schedule amounts. The fee schedule for physicians and certain suppliers lists payments for each Part B service and takes into account geographic variation in the cost of practice. The fee schedule amount is often less than the actual charges billed by doctors and suppliers. Part B usually pays 80 percent of the fee schedule amount, even if it is less than the actual charge.

When a Part B claim is submitted, the carrier compares the actual charge shown on the claim with the fee schedule amount for that service. The Medicare-approved amount is the lower of the actual charge or the fee schedule amount.

Submitting Part B Claims

Doctors, Suppliers and Other Providers Must Submit Claims for You

Since September 1, 1990, doctors, suppliers and other providers of Part B services have in most cases been **required to submit Medicare claims for you**, even if they do not take assignment. They must submit the claims within one year of providing the service to you or may be subject to certain penalties. (If you have other health insurance that should pay before Medicare, you can submit your claims yourself. See 'Filing Your Own Claims,' page 28.)

You should notify your Medicare carrier if your doctor or supplier refuses to submit a Part B Medicare claim for you if you believe the services may be covered by Medicare. (Phone numbers and addresses of carriers are listed on pages 36 to 41.)

How Does the Doctor or Supplier Submit Claims?

Your doctor or supplier must submit a form, called a HCFA-1500, requesting that Medicare Part B payment be made for your covered services, whether or not assignment is taken. The doctor or supplier should complete the HCFA-1500 form and send it to the proper Medicare carrier.

If your claim is for the rental or purchase of durable medical equipment, a doctor's prescription, or certificate of medical necessity, must be included with the claim. The prescription must show the equipment you need, the medical reason for the need, and an estimate of how long the equipment will be medically necessary.

If You are Enrolled in a Coordinated Care Plan

If you are enrolled in a coordinated care plan—a prepaid health care organization such as an HMO—a claim will seldom need to be submitted on your behalf. Medicare pays the HMO a set amount and the HMO provides your medical care. In most cases, you are

required to receive all non-emergency care through your HMO, or through arrangements they make before you receive care. However, if you get an out-of-plan service, the claim should be submitted directly to your HMO.

If your doctor or supplier needs an address, consult your HMO membership handbook, or contact the HMO.

Submitting Claims to the Railroad Retirement System

If you get Medicare under the Railroad Retirement system, the doctor or supplier must submit your claims to The Travelers Insurance Company office that serves your region. Regional offices of The Travelers are listed in *Your Medicare Handbook for Railroad Retirement Beneficiaries*, which is available at any Railroad Retirement office.

Filing Your Own Claims

In some cases, you may need to file your own Medicare Part B claims. You may file your own claims for:

- Services covered by Medicare for which you have other health insurance that should pay first on your claims.
- Services not covered by Medicare for which you want a formal Part B coverage determination.
- Services provided that your doctor or supplier refuses to submit for you, even though it is required by law.
- Services provided outside the United States. (Medicare coverage of services outside the United States is very limited and must meet special rules.)
- Used durable medical equipment purchased from a private source.

To find out whether you need to file your own claim, call or write your Medicare carrier. (Carrier addresses and phone numbers are listed on pages 36 to 41.)

Time Limits

Under the law, there are time limits for submitting your own Medicare Part B claims. For Medicare to make payments on your claims, you must send in your claims within these time limits. You always have at least 15 months to submit claims. The table below tells you exactly what the time limits are.

Time Limits

For service you get between	Your claim must be submitted by
Oct 1, 1990 & Sept 30, 1991	Dec 31, 1992
Oct 1, 1991 & Sept 30, 1992	Dec 31, 1993
Oct 1, 1992 & Sept 30, 1993	Dec 31, 1994

Claims for a Person Who Has Died

When a Medicare beneficiary dies, the way Medicare pays Part B* claims depends on whether the doctor's or supplier's bill has been paid.

If the bill was paid by the patient or with funds from the patient's estate, Medicare's payment will be made either to the estate representative or to a surviving member of the patient's immediate family. If someone other than the patient paid the bill, payment may be made to that person.

If the bill has **not** been paid and the doctor or supplier does not accept assignment, the Medicare payment can be made to the person who has or assumes legal obligation to pay the bill for the deceased patient.

Your Medicare carrier can provide additional information about how to claim a Medicare Part B payment after a patient dies.

Explanation of Your Medicare Part B Benefits Notice

After your doctor, provider, or supplier sends in a Part B claim, Medicare will send you a notice called *Explanation of Your Medicare Part B Benefits* to tell you the decision on the claim.

For services of a physician, this notice shows what services were covered, what charges were approved, how much was credited toward your $100 annual deductible, and the amount Medicare paid. For other Part B services the notice shows similar information. Please examine the notice carefully. If you believe payment was made for a service or supply you didn't receive, or the payment is

*Any Part A payments due to the hospital, skilled nursing facility, home health agency or hospice will be made directly to the provider of services.

otherwise questionable, call or write the carrier that handled your claim.

The address and toll-free telephone number you can use to contact your carrier is printed on the Explanation of Your Medicare Part B Benefits form. (Carriers are also listed on pages 36 to 41 of this handbook.)

Calling Your Medicare Carrier

Many carriers have installed an automated telephone answering system to help make their response to you faster and more accurate. When you call, if your carrier has a system of this type, you will be connected to a special automated voice system. If you have a touch-tone telephone, follow the instructions you receive over the phone to get information about the status of your claims.

If you need other information or want to talk about a claim, you can ask the system to connect you with a customer service representative at any time. **If you do not have a touch-tone telephone**, stay on the line after you dial and you will be connected to a customer service representative.

Getting the Part of Medicare You Do Not Have

Getting Medicare Medical Insurance (Part B)

If you have Medicare premium-free Hospital Insurance but do not have Medicare Part B, you can sign up for Part B during a general enrollment period. A general enrollment period is held January 1 through March 31 each year. Your protection will begin July 1 of the year you enroll. If you enroll during a general enrollment period, your monthly premium may be increased by 10 percent for each 12-month period you could have had Part B but were not enrolled. (If you are covered under an employer group health plan based on current employment as described on this page, the premium penalty may be decreased or waived.)

Getting Medicare Hospital Insurance (Part A)

Some people 65 or older have Medicare Medical Insurance (Part B), but do not meet the requirements for premium-free Part A. If you are in this category, you can get Part A by paying a monthly premium. This is called "premium hospital insurance." The Part A premium is $192 a month through December 31, 1992. (This amount will change January 1, 1993.)

You can sign up for premium Part A during a general enrollment period: January 1 through March 31 each year. If you enroll during a general enrollment period that begins more than one year after you became eligible to buy Part A, your monthly premium may be 10 percent higher than the basic premium amount. Your protection will begin July 1 of the year you enroll. (Also see this page for information on the special enrollment period.)

If you have been covered under an HMO, you can sign up for premium Part A at any time while you are in the HMO and up to eight months after the HMO coverage has ended. The premium penalty, if any, may be reduced because of the coverage under the HMO.

For more information about premium amounts, premium surcharges, and how to get the part of Medicare you do not have, contact Social Security.

Special Enrollment Period

If you are covered by an employer group health plan based on your own or your spouse's current employment (not a plan for retired people and their spouses), you may be able to delay enrollment in Medicare Medical Insurance (Part B) or premium Hospital Insurance (Part A) without premium penalty and without waiting for a general enrollment period to enroll. Delayed enrollment without penalty or wait is usually available if you are covered by an employer group health plan at the time you are first able to get Medicare.

In general, if you are 65 or over, you may enroll in Medicare Part B during the seven-month period beginning with the month:

- Your or your spouse's current employment ends, or
- Your coverage under the employer group health plan ends, whichever comes first.

If you are disabled and covered by an employer group health plan, you are also given a special enrollment period in certain circumstances. If you are covered under a group health plan based on current employment status when you are first able to get Medicare, you may enroll in Medicare Part B during the seven-month period that begins:

- When the employment status ends,
- When the plan is no longer classifiable as a **large** group health plan (one that covers 100 or more employees), or
- When the plan coverage is terminated.

Contact Social Security as soon as employment ends, or the plan coverage ends or changes, to be sure that you get the information you need about enrolling in Medicare Part B.

Events That Can Change Your Medicare Protection

When Protection Ends for People 65 and Older

If you have Medicare Hospital Insurance (Part A) based on your spouse's work record, your protection will end if you and your spouse divorce before your marriage has lasted 10 years. But if you have Part A based on your **own** work record, your protection will continue as long as you live.

Your Medicare Part B protection will stop if your premiums are not paid or if you voluntarily cancel. If you are thinking about cancelling your Part B, remember that you may not be able to get private insurance that offers the same protection. If you cancel your Part B and then later decide to re-enroll, you can only re-enroll during a general enrollment period (January 1 through March 31 of each year). Also, your premium may be higher and your protection will not begin again until July 1 of the year you re-enroll. (If you are covered under an employer group health plan based on current employment as described on page 9, the premium penalty may be decreased or waived.)

If you are buying Medicare Part A by paying monthly premiums (see page 30), you will lose it if you cancel your Medicare Part B. People who buy Medicare Part A must also enroll and pay the premium for Part B. But, you can cancel Part A and still continue to buy your Part B.

If you want more information about cancelling your Medicare protection, get in touch with Social Security.

When Protection Ends for the Disabled

If you have Medicare because you are disabled, your protection will end if you recover from your disability before you are 65. If you go to work but are still disabled, your premium-free Part A protection will continue for at least 48 months after you begin working. Your Part B will also continue for at least 48 months if you continue to pay the monthly premiums.

If you remain disabled and lose your premium-free Part A (and your Part B) solely because you are working, you may buy Part A only or both Part A and Part B. (You cannot buy Part B only.) You can continue to buy Medicare for as long as you remain disabled.

You may enroll during your initial enrollment period which begins with the month you are notified you are no longer eligible for premium-free Part A and continues for seven full months after that month. If you do not enroll during this initial enrollment period, you may enroll in a subsequent general enrollment period (January through March of each year).

If you ever want to cancel the Medicare protection for which you pay premiums, get in touch with Social Security.

When Protection Ends for Those With Permanent Kidney Failure

If you have Medicare because of permanent kidney failure, your protection will end 12 months after the month maintenance dialysis treatment stops or 36 months after the month you have a kidney transplant.

Your Medicare Part B protection could stop before that if you fail to pay the premiums, or if you decide to cancel. Call Social Security if you ever want to cancel your Part B protection.

If you need more information about Medicare coverage of permanent kidney failure, you can get a copy of *Medicare Coverage of Kidney Dialysis and Kidney Transplant Services* from Social Security or the Consumer Information Center (see inside back cover).

How to Appeal Medicare Decisions

If you disagree with a decision on the amount Medicare will pay on a claim or whether services you received are covered by Medicare, you have the right to appeal the decision. The notice you receive from Medicare tells you the decision made on the claim and also tells you exactly what appeal steps you can take. Appealing decisions by Part A providers, peer review organizations, intermediaries, carriers and health maintenance organizations are discussed below.

Appealing Decisions Made by Providers of Part A Services

In many cases the first written notice of noncoverage you receive will come from the provider of the services (for example, a hospital, skilled nursing facility, home health agency or hospice). This notice of noncoverage from the provider should explain why the provider believes Medicare will not pay for the services. This notice is not an official Medicare determination, but you can ask the provider to get an official Medicare determination. If you ask for an official Medicare determination, the provider must file a claim on your behalf to Medicare. Then you will receive a Notice of Utilization, which is the official Medicare determination. If you still disagree, you can appeal by following the instructions on the Notice of Utilization.

Appealing Decisions Made by Peer Review Organizations (PROs)

When you are admitted to a Medicare-participating hospital, you will be given a notice called *An Important Message From Medicare*. (See page 47 for a copy of this notice.) The notice contains a brief description of PROs, and the name, address and phone number of the PRO in your state. Also, it describes your appeal rights.

PROs make determinations mainly about inpatient hospital care and ambulatory surgical center care. The PROs decide whether care provided to Medicare patients is medically necessary, provided in the most appropriate setting, and is of good quality. When you disagree with a PRO decision about your case, you can appeal by requesting a reconsideration. Then, if you disagree with the PRO's reconsideration decision, and the amount remaining in question is $200 or more, you can request a hearing by an Administrative Law Judge. Cases involving $2,000 or more can eventually be appealed to a Federal Court.

If you belong to a Medicare health maintenance organization (HMO), the HMO will usually make decisions about the medical necessity, the appropriateness of setting and the quality of your care. In most cases, you do not have the right to appeal to the PRO, but you always have the right to register complaints about the quality of your hospital care to the PRO. (See page 33 for more information about appeal rights for members of HMOs.)

NOTE: In the case of elective (non-emergency) surgery, either the hospital or the PRO may be involved in pre-admission decisions. If the hospital believes that your proposed stay will not be covered by Medicare, it may recommend, without consulting the PRO, that you not be admitted to the hospital. If this is the case, the hospital must give you its decision in writing. If you or your doctor disagree with the hospital's decision, you should make a request to the PRO for immediate review. If you want an immediate review, you must make your request, by telephone or in writing, within three calendar days after receipt of the notice.

Appealing Decisions of Intermediaries on Part A Claims

Appeals of decisions on most other services covered under Medicare Part A (skilled nursing facility care, home health care, hospice services, and a few inpatient hospital matters not handled by PROs) are handled by Medicare intermediaries. If you disagree with the intermediary's initial decision, you have 60 days from the date you receive the initial decision to request a reconsideration. The request can be submitted directly to the intermediary or through Social Security. If you disagree with the intermediary's reconsideration decision and the amount remaining in question is $100 or more, you have 60 days from the date you receive the reconsideration decision to request a hearing by an Administrative Law Judge. Cases involving $1,000 or more can eventually be appealed to a Federal Court.

Appealing Decisions Made by Carriers on Part B Claims

Your doctor must provide you with a written notice if he or she knows or believes that Medicare will not consider a particular service reasonable and necessary and will not pay for it. This written notice must be given to you before the service is performed and must clearly state the reasons your doctor believes Medicare will not pay. If your doctor does not give you this written notice and you did not know that Medicare would not pay for the services you received, you cannot be held liable to pay for them. However, if you did receive written notice and signed an agreement to pay for the services yourself so you could be treated, you will be held liable to pay.

This written notice is not an official Medicare determination. If you disagree with it, you may ask your doctor to submit a claim for payment to the Medicare carrier to get an official Medicare determination. The claim must be filed within the specific time periods shown on page 28. In some cases you can file the claim yourself. If you receive an adverse decision from Medicare and you still disagree, you have the right to appeal that decision. You have six months from the date of the decision to ask the carrier to review it. Then, if you disagree with the carrier's written explanation of its review decision and the amount remaining in question is $100 or more, you have six months from the date of the review decision to request a hearing before a carrier hearing officer. You may combine claims that have been reviewed or reopened within the past six months, to meet the $100 requirement.

If you disagree with the carrier hearing officer's decision and the amount remaining in question is $500 or more, you have 60 days from the date you receive the decision to request a hearing before an Administrative Law Judge. You may combine claims that have had a hearing decision within the past 60 days to meet the $500 requirement. Cases involving $1,000 or more can eventually be appealed to a Federal Court.

Appealing Decisions Made by Health Maintenance Organizations (HMOs)

If you have Medicare coverage through an HMO, decisions about coverage and payment for services will usually be made by your HMO. When your HMO makes a decision to deny payment for Medicare-covered services or refuses to provide Medicare-covered supplies you request, you will be given a *Notice of Initial Determination.* Along with the notice, your HMO is required to provide a full, written explanation of your appeal rights.

If you believe that the decision your HMO made was not correct, you have the right to ask for a reconsideration. You must file your request for reconsideration within 60 days of the *Notice of Initial Determination.* Your request must be in writing. You may mail it or deliver it personally to your HMO or to a Social Security office (or the Railroad Retirement Board if you get Medicare through Railroad Retirement).

Your HMO is responsible for reconsidering their initial determination to deny payment or services. If your HMO does not rule fully in your favor, the HMO must send your reconsideration request to the Health Care Financing Administration (HCFA) for a review and determination.

If you disagree with HCFA's decision, and the amount in question is $100 or more, you have 60 days from receipt of HCFA's decision to request a hearing before an Administrative Law Judge. Cases involving $1,000 or more can eventually be appealed to a Federal Court.

For More Information

If you need more information about your right to appeal and how to request it, call Social Security, or the Medicare intermediary or carrier in your state. (The number of the Medicare intermediary or carrier is listed on the notice explaining Medicare's decision on the claim. Medicare carriers are also listed on pages 36 to 41.) If you need more information about your right to appeal a Peer Review Organization (PRO) decision, you can call the PRO in your state. (PROs are listed on pages 42 to 46).

MEDICARE (PART A): HOSPITAL INSURANCE-COVERED SERVICES FOR 1992

Services	Benefit	Medicare Pays	You Pay
HOSPITALIZATION Semiprivate room and board, general nursing and miscellaneous hospital services and supplies. (Medicare payments based on benefit periods, see page 12).	First 60 days	All but $652	$652
	61st to 90th day	All but $163 a day	$163 a day
	91st to 150th day[1]	All but $326 a day	$326 a day
	Beyond 150 days	Nothing	All costs
SKILLED NURSING FACILITY CARE You must have been in a hospital for at least 3 days and enter a Medicare-approved facility generally within 30 days after hospital discharge.[2] (Medicare payments based on benefit periods, see page 12.)	First 20 days	100% of approved amount	Nothing
	Additional 80 days	All but $81.50 a day	$81.50 a day
	Beyond 100 days	Nothing	All costs
HOME HEALTH CARE Medically necessary skilled care.	Part-time or intermittent care for as long as you meet Medicare conditions.	100% of approved amount; 80% of approved amount for durable medical equipment.	Nothing for services; 20% of approved amount for durable medical equipment.
HOSPICE CARE Pain relief, symptom management and support services for the terminally ill.	If you elect the hospice option and as long as doctor certifies need.	All but limited costs for outpatient drugs and inpatient respite care.	Limited cost sharing for outpatient drugs and inpatient respite care.
BLOOD	Unlimited if medically necessary.	All but first 3 pints per calendar year.	For first 3 pints.[3]

1992 Part A monthly premium: None for most beneficiaries.
$192 if you must buy Part A (Premium may be higher if you enroll late).

[1] This 60-reserve-days benefit may be used only once in a lifetime (see page 13).
[2] Neither Medicare nor private Medigap insurance will pay for most nursing home care (see page 15).
[3] To the extent the blood deductible is met under one part of Medicare during the calendar year, it does not have to be met under the other part.

MEDICARE (PART B): MEDICAL INSURANCE-COVERED SERVICES FOR 1992

Services	Benefit	Medicare Pays	You Pay
MEDICAL EXPENSES Doctors' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, ambulance, diagnostic tests, and more.	Medicare pays for medical services in or out of the hospital.	80% of approved amount (after $100 deductible).	$100 deductible,[1] plus 20% of approved amount and limited charges above approved amount.[2]
CLINICAL LABORATORY SERVICES Blood tests, biopsies, urinalyses, and more.	Unlimited if medically necessary.	100% of approved amount.	Nothing for services.
HOME HEALTH CARE Medically necessary skilled care.	Part-time or intermittent skilled care for as long as you meet conditions for benefits.	100% of approved amount; 80% of approved amount for durable medical equipment.	Nothing for services; 20% of approved amount for durable medical equipment.
OUTPATIENT HOSPITAL TREATMENT Services for the diagnosis or treatment of illness or injury.	Unlimited if medically necessary.	80% of approved amount (after $100 deductible).	$100 deductible, plus 20% of billed charges.
BLOOD	Unlimited if medically necessary.	80% of approved amount (after $100 deductible and starting with 4th pint).	First 3 pints plus 20% of approved amount for additional pints (after $100 deductible).[3]

1992 Part B monthly premiums: $31.80 (Premium may be higher if you enroll late).

[1] Once you have had $100 of expenses for covered services in 1992, the Part B deductible does not apply to any further covered services you receive for the rest of the year.

[2] See 'When Your Doctor Does Not Accept Assignment,' page 26.

[3] To the extent the blood deductible is met under one part of Medicare during the calendar year, it does not have to be met under the other part.

MEDICARE CARRIERS

Carriers can answer questions about Medical Insurance (Part B)

Note:
- **The toll-free or 800 numbers listed below can be used only in the states where the carriers are located.** Also listed are the local commercial numbers for the carriers. Out-of-state callers must use the commercial numbers.
- These carrier toll-free numbers are for beneficiaries to use and should not be used by doctors and suppliers.
- Many carriers have installed an automated telephone answering system. If you have a touch-tone telephone, you can follow the system instructions to find out about your latest claims and get other information. If you do not have a touch-tone telephone, stay on the line and someone will help you.

ALABAMA
Medicare/Blue Cross-Blue Shield of Alabama
P.O. Box 830-140
Birmingham, Alabama 35283-0140
1-800-292-8855
205-988-2244

ALASKA
Medicare/Aetna Life & Casualty
200 S.W. Market St.
P.O. Box 1997
Portland, Oregon 97207-1997
1-800-547-6333
503-222-6831 (customer service site actually in Oregon)

ARIZONA
Medicare/Aetna Life & Casualty
P.O. Box 37200
Phoenix, Arizona 85069
1-800-352-0411
602-861-1968

ARKANSAS
Medicare/Arkansas Blue Cross and Blue Shield
A Mutual Insurance Company
P.O. Box 1418
Little Rock, Arkansas 72203-1418
1-800-482-5525
501-378-2320

CALIFORNIA
Counties of: Los Angeles, Orange, San Diego, Ventura, Imperial, San Luis Obispo, Santa Barbara
Medicare/Transamerica Occidental Life Insurance Co.
Box 50061
Upland, California 91785-5061
1-800-675-2266
213-748-2311
Rest of state: Medicare Claims Dept.
Blue Shield of California
Chico, California 95976
(In area codes 209, 408,415, 707, 916)
1-800-952-8627
916-743-1587
(In the following area codes—**other than Los Angeles, Orange, San Diego, Ventura, Imperial, San Luis Obispo, and Santa Barbara counties**—213, 619, 714, 805, 818)
1-800-848-7713
714-824-0900

COLORADO
Medicare/Blue Cross and Blue Shield of Colorado
Coordination of Benefits:
P.O. Box 173550
Denver, Colorado 80217
Correspondence/Appeals:
P.O. Box 173500
Denver, Colorado 80217
(Metro Denver) 303-831-2661
(In Colorado, outside of metro area) 1-800-332-6681

CONNECTICUT
Medicare/The Travelers Companies
538 Preston Avenue
P.O. Box 9000
Meriden, Connecticut 06454-9000
1-800-982-6819
(In Hartford) 203-728-6783
(In the Meriden area) 203-237-8592

DELAWARE
Medicare/Pennsylvania Blue Shield
P.O. Box 890200
Camp Hill, Pennsylvania 17089-0200
1-800-851-3535

DISTRICT OF COLUMBIA
Medicare/Pennsylvania Blue Shield
P.O. Box 890100
Camp Hill, Pennsylvania 17089-0100
1-800-233-1124

FLORIDA
Medicare/Blue Shield of Florida, Inc.
P.O. Box 2525
Jacksonville, Florida 32231
For fast service on simple inquiries including requests for copies of Explanation of Your Medicare Part B Benefits notices, requests for MEDPAR directories, brief claims inquiries (status or verification of receipt), and address changes:
1-800-666-7586
904-355-8899
For all your other Medicare needs:
1-800-333-7586
904-355-3680

MEDICARE CARRIERS

Carriers can answer questions about Medical Insurance (Part B)

GEORGIA
Medicare/Aetna Life & Casualty
P.O. Box 3018
Savannah, Georgia 31402-3018
1-800-727-0827
912-920-2412

HAWAII
Medicare/Aetna Life & Casualty
P.O. Box 3947
Honolulu, Hawaii 96812
1-800-272-5242
808-524-1240

IDAHO
EQUICOR/CIGNA
3150 N. Lakeharbor Lane, Suite 254
P.O. Box 8048
Boise, Idaho 83707-6219
1-800-627-2782
208-342-7763

ILLINOIS
Medicare Claims/Blue Cross & Blue Shield of Illinois
P.O. Box 4422
Marion, Illinois 62959
1-800-642-6930
312-938-8000

INDIANA
Medicare Part B/AdminaStar Federal
P.O. Box 7073
Indianapolis, Indiana 46207
1-800-622-4792
317-842-4151

IOWA
Medicare/IASD Health Services Inc.
(d/b/a Blue Cross & Blue Shield of Iowa)
636 Grand
Des Moines, Iowa 50309
1-800-532-1285
515-245-4785

KANSAS
Counties of: Johnson, Wyandotte
Medicare/Blue Shield of Kansas City
P.O. Box 419840
Kansas City, Missouri 64141-6840
1-800-892-5900
816-561-0900
Rest of state: Medicare/Blue Cross and Blue Shield of Kansas
P.O. Box 239
Topeka, Kansas 66601
1-800-432-3531
913-232-3773

KENTUCKY
Medicare-Part B/Blue Cross & Blue Shield of Kentucky
100 East Vine St.
Lexington, Kentucky 40507
1-800-999-7608
606-233-1441

LOUISIANA
Arkansas Blue Cross & Blue Shield
Medicare Administration
P.O. Box 83830
Baton Rouge, Louisiana 70884-3830
1-800-462-9666
(In New Orleans) 504-529-1494
(In Baton Rouge) 504-927-3490

MAINE
Medicare B
C and S Administrative Services
P.O. Box 9790
Portland, Maine 04104-5090
1-800-492-0919
207-828-4300

MARYLAND
Counties of: Montgomery, Prince Georges
Medicare/Pennsylvania Blue Shield
P.O. Box 890100
Camp Hill, Pennsylvania 17089-0100
1-800-233-1124
Rest of state: Maryland Blue Shield, Inc.
1946 Greenspring Drive
Timonium, Maryland 21093
1-800-492-4795
410-561-4160

MEDICARE CARRIERS

Carriers can answer questions about Medical Insurance (Part B)

MASSACHUSETTS
Medicare C and S Administrative Services
1022 Hingham Street
Rockland, Massachusetts 02371
1-800-882-1228
617-956-3994

MICHIGAN
Medicare Part B
Michigan Blue Cross & Blue Shield
P.O. Box 2201
Detroit, Michigan 48231-2201
(In area code 313) 1-800-482-4045
(In area code 517) 1-800-322-0607
(In area code 616) 1-800-442-8020
(In area code 906) 1-800-562-7802
(In Detroit) 313-225-8200

MINNESOTA
Counties of: Anoka, Dakota, Fillmore,
Goodhue, Hennepin, Houston, Olmstead,
Ramsey, Wabasha, Washington, Winona
Medicare/The Travelers Ins. Co.
8120 Penn Avenue South
Bloomington, Minnesota 55431
1-800-352-2762
612-884-7171
Rest of state: Medicare/Blue Shield of Minnesota
P.O. Box 64357
St. Paul, Minnesota 55164
1-800-392-0343
612-456-5070

MISSISSIPPI
Medicare/The Travelers Ins. Co.
P.O. Box 22545
Jackson, Mississippi 39225-2545
(In Mississippi) 1-800-682-5417
(Outside of Mississippi) 1-800-227-2349
601-956-0372

MISSOURI
Counties of: Andrew, Atchison, Bates,
Benton, Buchanan, Caldwell, Carroll, Cass,
Clay, Clinton, Daviess, DeKalb, Gentry,
Grundy, Harrison, Henry, Holt, Jackson, Johnson, Lafayette,
Livingston, Mercer, Nodaway, Pettis, Platte, Ray, St. Clair,
Saline, Vernon, Worth
Medicare/Blue Shield of Kansas City
P.O. Box 419840
Kansas City, Missouri 64141-6840
1-800-892-5900
816-561-0900
Rest of state: Medicare
General American Life Insurance Co.
P.O. Box 505
St. Louis, Missouri 63166
1-800-392-3070
314-843-8880

MONTANA
Medicare/Blue Cross and Blue Shield of Montana
2501 Beltview
P.O. Box 4310
Helena, Montana 59604
1-800-332-6146
406-444-8350

NEBRASKA
The carrier for Nebraska is Blue Shield of Kansas.
Claims, however, should be sent to:
Medicare Part B
Blue Cross/Blue Shield of Nebraska
P.O. Box 3106
Omaha, Nebraska 68103-0106
1-800-633-1113
913-232-3773 (customer service site in Kansas)

NEVADA
Medicare/Aetna Life and Casualty
P.O. Box 37230
Phoenix, Arizona 85069
1-800-528-0311
602-861-1968

NEW HAMPSHIRE
Medicare B
C and S Administrative Services
P.O. Box 9790
Portland, Maine 04104-5090
1-800-447-1142
207-828-4300

MEDICARE CARRIERS

Carriers can answer questions about Medical Insurance (Part B)

NEW JERSEY
Medicare/Pennsylvania Blue Shield
P.O. Box 400010
Harrisburg, Pennsylvania 17140-0010
1-800-462-9306
717-975-7333

NEW MEXICO
Medicare/Aetna Life and Casualty
P.O. Box 25500
Oklahoma City, Oklahoma 73125-0500
1-800-423-2925
(In Albuquerque) 505-843-7771

NEW YORK
Counties of: Bronx, Kings, New York, Richmond
Medicare B/Empire Blue Cross and Blue Shield
P.O. Box 2280
Peekskill, New York 10566
516-244-5100
Counties of: Columbia, Delaware, Dutchess, Greene, Nassau, Orange, Putnam, Rockland, Suffolk, Sullivan, Ulster, Westchester
Medicare B/Empire Blue Cross and Blue Shield
P.O. Box 2280
Peekskill, New York 10566
1-800-442-8430
516-244-5100
County of: Queens
Medicare/Group Health, Inc.
P.O. Box 1608, Ansonia Station
New York, New York 10023
212-721-1770
Rest of state: Medicare
Blue Shield of Western New York
7-9 Court Street
Binghamton, New York 13901-3197
607-772-6906
1-800-252-6550

NORTH CAROLINA
Connecticut General Life Insurance Company
P.O. Box 671
Nashville, Tennessee 37202
1-800-672-3071
919-665-0348

NORTH DAKOTA
Medicare/Blue Shield of North Dakota
4510 13th Avenue, S.W.
Fargo, North Dakota 58121-0001
1-800-247-2267
701-282-0691

OHIO
Medicare/Nationwide Mutual Ins. Co.
P.O. Box 57
Columbus, Ohio 43216
1-800-282-0530
614-249-7157

OKLAHOMA
Medicare/Aetna Life and Casualty
701 N.W. 63rd St.
Oklahoma City, Oklahoma 73116-7693
1-800-522-9079
405-848-7711

OREGON
Medicare/Aetna Life and Casualty
200 S.W. Market St.
P.O. Box 1997
Portland, Oregon 97207-1997
1-800-452-0125
503-222-6831

PENNSYLVANIA
Medicare/Pennsylvania Blue Shield
P.O. Box 890065
Camp Hill, Pennsylvania 17089-0065
1-800-382-1274
717-763-3601

RHODE ISLAND
Medicare/ Blue Cross and Blue Shield of Rhode Island
444 Westminster Street
Providence, Rhode Island 02903-3279
1-800-662-5170
401-861-2273

SOUTH CAROLINA
Medicare Part B
Blue Cross and Blue Shield of South Carolina
Fontaine Road Business Center
300 Arbor Lake Drive, Suite 1300
Columbia, South Carolina 29223
1-800-868-2522
803-754-0639

MEDICARE CARRIERS

Carriers can answer questions about Medical Insurance (Part B)

SOUTH DAKOTA
Medicare Part B/Blue Shield of North Dakota
4510 13th Avenue, S.W.
Fargo, North Dakota 58121-0001
1-800-437-4762
701-282-0691

TENNESSEE
Connecticut General Life Insurance Company
P.O. Box 1465
Nashville, Tennessee 37202
1-800-342-8900
615-244-5650

TEXAS
Medicare/Blue Cross & Blue Shield of Texas, Inc.
P.O. Box 660031
Dallas, Texas 75266-0031
1-800-442-2620
214-235-3433

UTAH
Medicare/Blue Shield of Utah
P.O. Box 30269
Salt Lake City, Utah 84130-0269
1-800-426-3477
801-481-6196

VERMONT
Medicare B
C and S Administrative Services
P.O. Box 9790
Portland, Maine 04104-5090
1-800-447-1142
207-828-4300

VIRGINIA
Counties of: Arlington, Fairfax;
Cities of: Alexandria, Falls Church, Fairfax
Medicare/Pennsylvania Blue Shield
P.O. Box 890100
Camp Hill, Pennsylvania 17089-0100
1-800-233-1124
717-763-3601
Rest of state: Medicare/The Travelers Ins. Co.
P.O. Box 26463
Richmond, Virginia 23261
1-800-552-3423
804-330-4786

WASHINGTON
Medicare
Washington State Medicare Part B
P.O. Box 91070
Seattle, Washington 98111-9170
(In Seattle) 1-800-422-4087
206-464-3711
(In Spokane) 1-800-572-5256
509-536-4550
(In Tacoma) 206-597-6530

WEST VIRGINIA
Medicare/Nationwide Mutual Insurance Co.
P.O. Box 57
Columbus, Ohio 43216
1-800-848-0106
614-249-7157

WISCONSIN
Medicare/WPS
Box 1787
Madison, Wisconsin 53701
1 800-362-7221
(In Madison) 608-221-3330
(In Milwaukee) 414-931-1071

WYOMING
Blue Cross/Blue Shield of Wyoming
P.O. Box 628
Cheyenne, Wyoming 82003
1-800-442-2371
307-632-9381

AMERICAN SAMOA
Medicare/Hawaii Medical Services Assn.
P.O. Box 860
Honolulu, Hawaii 96808
808-944-2247

GUAM
Medicare/Aetna Life and Casualty
P.O. Box 3947
Honolulu, Hawaii 96812
808-524-1240

MEDICARE CARRIERS

Carriers can answer questions about Medical Insurance (Part B)

NORTHERN MARIANA ISLANDS
Medicare/Aetna Life & Casualty
P.O. Box 3947
Honolulu, Hawaii 96812
808-524-1240

PUERTO RICO
Medicare/Seguros De Servicio De
Salud De Puerto Rico
Call Box 71391
San Juan, Puerto Rico 00936

(In Puerto Rico)	800-462-7015
(In U.S. Virgin Islands)	800-474-7448
(In Puerto Rico metro area)	809-749-4900

VIRGIN ISLANDS
Medicare/Seguros De Servicio De
Salud De Puerto Rico
Call Box 71391
San Juan, Puerto Rico 00936

(In U.S. Virgin Islands)	800-474-7448

MEDICARE PEER REVIEW ORGANIZATIONS (PROs)

PROs can answer questions about hospital stays and other Hospital Insurance (Part A) services. Do not call the PRO with questions about Medicare Medical Insurance (Part B).

ALABAMA
Alabama Quality Assurance Foundation, Inc.
Suite 600
600 Beacon Parkway West
Birmingham, AL 35209-3154
1-800-288-4992

ALASKA
Professional Review Organization for Washington
(PRO for Alaska)
Suite 100
10700 Meridian Avenue, North
Seattle, WA 98133-9008
1-800-445-6941
(in Anchorage dial 562-2252)

AMERICAN SAMOA/GUAM AND HAWAII
Hawaii Medical Service Association
(PRO for American Samoa/Guam
and Hawaii)
818 Keeaumoku Street
P.O. Box 860
Honolulu, HI 96808
1-808-944-3586*

ARIZONA
Health Services Advisory Group, Inc.
P.O. Box 16731
Phoenix, AZ 85011-6731
1-800-626-1577
(in Arizona dial 1-800-359-9909 or 1-800-223-6693)

ARKANSAS
Arkansas Foundation for Medical Care, Inc.
P.O. Box 2424
809 Garrison Avenue
Fort Smith, AR 72902
1-800-824-7586
(in Arkansas dial 1-800-272-5528)

CALIFORNIA
California Medical Review, Inc.
Suite 500
60 Spear Street
San Francisco, CA 94105
1-800-841-1602 (in-state only)
1-415-882-5800*

COLORADO
Colorado Foundation for Medical Care
1260 South Parker Road
P.O. Box 17300
Denver, CO 80217-0300
1-800-727-7086 (in-state only)
1-303-695-3333*

CONNECTICUT
Connecticut Peer Review Organization, Inc.
100 Roscommon Drive, Suite 200
Middletown, CT 06457
1-800-553-7590 (in-state only)
1-203-632-2008*

DELAWARE
West Virginia Medical Institute, Inc.
(PRO for Delaware)
3001 Chesterfield Place
Charleston, WV 25304
1-800-642-8686 ext. 266
(in Wilmington dial 655-3077)

DISTRICT OF COLUMBIA
Delmarva Foundation for Medical Care, Inc.
(PRO for D.C.)
9240 Centreville Road
Easton, MD 21601
1-800-645-0011
(in Maryland dial 1-800-492-5811)

FLORIDA
Blue Cross and Blue Shield of Florida, Inc.
PRO Review
P.O. Box 45267
Jacksonville, FL 32232-5267
1-800-964-5784 (in-state only)
904-791-8262

GEORGIA
Georgia Medical Care Foundation
Suite 200
57 Executive Park South
Atlanta, GA 30329
1-800-282-2614 (in-state only)
404-982-0411

*PRO will accept collect calls from out of state on this number.

MEDICARE PEER REVIEW ORGANIZATIONS (PROs)

PROs can answer questions about hospital stays and other Hospital Insurance (Part A) services. Do not call the PRO with questions about Medicare Medical Insurance (Part B).

HAWAII
Hawaii Medical Service Association
(PRO for American Samoa/Guam and Hawaii)
818 Keeaumoku Street
P.O. Box 860
Honolulu, HI 96808
1-808-944-3586*

IDAHO
Professional Review Organization for Washington
(PRO for Idaho)
Suite 100
10700 Meridian Avenue, North
Seattle, WA 98133-9008
1-800-445-6941
1-208-343-4617* (local Boise and collect)

ILLINOIS
Crescent Counties Foundation for Medical Care
350 Shuman Boulevard, Suite 240
Naperville, IL 60563
1-800-647-8089

INDIANA
Sentinel Medical Review Organization
2901 Ohio Boulevard
P.O. Box 3713
Terre Haute, IN 47803
1-800-288-1499

IOWA
Iowa Foundation for Medical Care
Suite 350E
6000 Westown Parkway
West Des Moines, IA 50265-7771
1-800-752-7014 (in-state only)
515-223-2900

KANSAS
The Kansas Foundation for Medical Care, Inc.
2947 S.W. Wanamaker Drive
Topeka, KS 66614
1-800-432-0407 (in-state only)
913-273-2552

KENTUCKY
Sentinel Medical Review Organization
10503 Timberwood Circle, Suite 200
P.O. Box 23540
Louisville, KY 40223
1-800-288-1499

LOUISIANA
Louisiana Health Care Review, Inc.
8591 United Plaza Blvd., Suite 270
Baton Rouge, LA 70809
1-800-433-4958 (in-state only)
504-926-6353

MAINE
Health Care Review, Inc.
(PRO for Maine)
Henry C. Hall Building
345 Blackstone Blvd.
Providence, RI 02906
1-800-541-9888 or 1-800-528-0700 (both numbers in Maine only)
1-207-945-0244*

MARYLAND
Delmarva Foundation for Medical Care, Inc.
(PRO for Maryland)
9240 Centreville Road
Easton, MD 21601
1-800-645-0011
(in Maryland dial 1-800-492-5811)

MASSACHUSETTS
Massachusetts Peer Review Organization, Inc.
300 Bearhill Road
Waltham, MA 02154
1-800-252-5533 (in-state only)
1-617-890-0011*

MICHIGAN
Michigan Peer Review Organization
40600 Ann Arbor Road, Suite 200
Plymouth, MI 48170
1-800-365-5899

MINNESOTA
Foundation for Health Care Evaluation
Suite 400
2901 Metro Drive
Bloomington, MN 55425
1-800-444-3423

*PRO will accept collect calls from out of state on this number.

MEDICARE PEER REVIEW ORGANIZATIONS (PROs)

PROs can answer questions about hospital stays and other Hospital Insurance (Part A) services. Do not call the PRO with questions about Medicare Medical Insurance (Part B).

MISSISSIPPI
Mississippi Foundation for Medical Care, Inc.
P.O. Box 4665
735 Riverside Drive
Jackson, MS 39296-4665
1-800-844-0600 (in-state only)
601-948-8894

MISSOURI
Missouri Patient Care Review Foundation
505 Hobbs Road, Suite 100
Jefferson City, MO 65109
1-800-347-1016

MONTANA
Montana-Wyoming Foundation for Medical Care
400 North Park, 2nd Floor
Helena, MT 59601
1-800-332-3411 (in-state only)
1-406-443-4020*

NEBRASKA
Iowa Foundation for Medical Care
(PRO for Nebraska)
Suite 350E
6000 Westown Parkway
West Des Moines, IA 50265-7771
1-800-247-3004 (in Nebraska only)
515-223-2900

NEVADA
Nevada Peer Review
675 East 2100 South, Suite 270
Salt Lake City, UT 84106-1864
1-800-558-0829 (in Nevada only)
(in Reno dial 1-702-826-1996)
1-702-385-9933*

NEW HAMPSHIRE
New Hampshire Foundation for Medical Care
15 Old Rollinsford Road
Dover, NH 03820
1-800-582-7174 (in-state only)
1-603-749-1641*

NEW JERSEY
The Peer Review Organization of New Jersey, Inc.
Central Division
Brier Hill Court, Building J
East Brunswick, NJ 08816
1-800-624-4557 (in-state only)
1-201-238-5570*

NEW MEXICO
New Mexico Medical Review Association
707 Broadway N.E., Suite 200
P.O. Box 27449
Albuquerque, NM 87125-7449
1-800-432-6824 (in-state only)
505-842-6236
(In Albuquerque dial 824-6236)

NEW YORK
Island Peer Review Organization, Inc.
1979 Marcus Avenue, First floor
Lake Success, NY 11042
1-800-331-7767 (in-state only)
1-516-326-7767*
(in metro area and New York City dial 326-7767)

NORTH CAROLINA
Medical Review of North Carolina
Suite 200
P.O. Box 37309
1011 Schaub Drive
Raleigh, NC 27627
1-800-682-2650 (in-state only)
919-851-2955

NORTH DAKOTA
North Dakota Health Care Review, Inc.
Suite 301
900 North Broadway
Minot, ND 58701
1-800-472-2902 (in-state only)
1-701-852-4231*

OHIO
Peer Review Systems, Inc.
Suite 250
3700 Corporate Drive
Columbus, OH 43231-4996
1-800-233-7337

*PRO will accept collect calls from out of state on this number.

MEDICARE PEER REVIEW ORGANIZATIONS (PROs)

PROs can answer questions about hospital stays and other Hospital Insurance (Part A) services. Do not call the PRO with questions about Medicare Medical Insurance (Part B).

OKLAHOMA
Oklahoma Foundation for Peer Review, Inc.
Suite 400 The Paragon Building
5801 Broadway Extension
Oklahoma City, OK 73118-7489
1-800-522-3414 (in-state only)
405-840-2891

OREGON
Oregon Medical Professional Review Organization
Suite 200
1220 Southwest Morrison
Portland, OR 97205
1-800-344-4354 (in-state only)
503-279-0100*

PENNSYLVANIA
Keystone Peer Review Organization, Inc.
777 East Park Drive
P.O. Box 8310
Harrisburg, PA 17105-8310
1-800-322-1914 (in-state only)
717-564-8288

PUERTO RICO
Puerto Rico Foundation for Medical Care
Suite 605 Mercantile Plaza
Hato Rey, PR 00918
1-809-753-6705* or 1-809-753-6708*

RHODE ISLAND
Health Care Review, Inc.
Henry C. Hall Building
345 Blackstone Boulevard
Providence, RI 02906
1-800-221-1691 (New England-wide)
(in Rhode Island dial 1-800-662-5028)
1-401-331-6661*

SOUTH CAROLINA
Carolina Medical Review
101 Executive Center Drive
Suite 123
Columbia, SC 29210
1-800-922-3089 (in-state only)
803-731-8225

SOUTH DAKOTA
South Dakota Foundation for Medical Care
1323 South Minnesota Avenue
Sioux Falls, SD 57105
1-800-658-2285

TENNESSEE
Mid-South Foundation for Medical Care
Suite 400
6401 Poplar Avenue
Memphis, TN 38119
1-800-873-2273

TEXAS
Texas Medical Foundation
Barton Oaks Plaza Two, Suite 200
901 Mopac Expressway South
Austin, TX 78746
1-800-777-8315 (in-state only)
512-329-6610

UTAH
Utah Peer Review Organization
675 East 2100 South
Suite 270
Salt Lake City, UT 84106-1864
1-800-274-2290

VERMONT
New Hampshire Foundation for Medical Care
(PRO for Vermont)
15 Rollinsford Road, Suite 302
Dover, NH 03820
1-800-639-8427 (in Vermont only)
1-802-655-6302*

VIRGIN ISLANDS
Virgin Islands Medical Institute
IAD Estate Diamond Ruby
P.O. Box 1566
Christiansted
St. Croix, U.S.A. VI 00821-1566
1-809-778-6470*

*PRO will accept collect calls from out of state on this number.

MEDICARE PEER REVIEW ORGANIZATIONS (PROs)

PROs can answer questions about hospital stays and other Hospital Insurance (Part A) services. Do not call the PRO with questions about Medicare Medical Insurance (Part B).

VIRGINIA
Medical Society of Virginia Review Organization
1606 Santa Rosa Road, Suite 235
P.O. Box K 70
Richmond, VA 23288
1-800-545-3814 (DC, MD and VA)
804-289-5320
(in Richmond, dial 289-5397)

WASHINGTON
Professional Review Organization for Washington
Suite 100
10700 Meridian Avenue, North
Seattle, WA 98133-9008
1-800-445-6941
(in Seattle, dial 368-8272)

WEST VIRGINIA
West Virginia Medical Institute, Inc.
3001 Chesterfield Place
Charleston, WV 25304
1-800-642-8686, ext. 266
(in Charlestown, dial 346-9864)

WISCONSIN
Wisconsin Peer Review Organization
2909 Landmark Place
Madison, WI 53713
1-800-362-2320 (in-state only)
608-274-1940

WYOMING
Montana-Wyoming Foundation for Medical Care
400 North Park, 2nd Floor
Helena, MT 59601
1-800-826-8978 (in Wyoming only)
1-406-443-4020*

*PRO will accept collect calls from out of state on this number.

AN IMPORTANT MESSAGE FROM MEDICARE

YOUR RIGHTS WHILE YOU ARE A MEDICARE HOSPITAL PATIENT

- You have the right to receive all the hospital care that is necessary for the proper diagnosis and treatment of your illness or injury. According to Federal law, your discharge date must be determined solely by your medical needs, not by "DRGs" or Medicare payments.
- You have the right to be fully informed about decisions affecting your Medicare coverage and payment for your hospital stay and for any post-hospital services.
- You have the right to request a review by a Peer Review Organization of any written Notice of Noncoverage that you receive from the hospital stating that Medicare will no longer pay for your hospital care. Peer Review Organizations (PROs) are groups of doctors who are paid by the Federal Government to review medical necessity, appropriateness and quality of hospital treatment furnished to Medicare patients. The phone number and address of the PRO for your area are:

_____

_____

_____

TALK TO YOUR DOCTOR ABOUT YOUR STAY IN THE HOSPITAL

You and your doctor know more about your condition and your health needs than anyone else. Decisions about your medical treatment should be made between you and your doctor. If you have any questions about your medical treatment, your need for continued hospital care, your discharge, or your need for possible post-hospital care, don't hesitate to ask your doctor. The hospital's patient representative or social worker will also help you with your questions and concerns about hospital services.

IF YOU THINK YOU ARE BEING ASKED TO LEAVE THE HOSPITAL TOO SOON

- Ask a hospital representative for a written notice of explanation immediately, if you have not already received one. This notice is called a "Notice of Noncoverage." You must have this Notice of Noncoverage if you wish to exercise your right to request a review by the PRO.
- The Notice of Noncoverage will state either that your doctor or the PRO agrees with the hospital's decision that Medicare will no longer pay for your hospital care.
    - + If the hospital and your doctor agree, the PRO does not review your case before a Notice of Noncoverage is issued. But the PRO will respond to your request for a review of your Notice of Noncoverage and seek your opinion. You cannot be made to pay for your hospital care until the PRO makes its decision, if you request the review by noon of the first work day after you receive the Notice of Noncoverage.
    - + If the hospital and your doctor disagree, the hospital may request the PRO to review your case. If it does make such a request, the hospital is required to send you a notice to that effect. In this situation the PRO must agree with the hospital or the hospital cannot issue a Notice of Noncoverage. You may request that the PRO reconsider your case after you receive a Notice of Noncoverage but since the PRO has already reviewed your case once, you may have to pay for at least one day of hospital care before the PRO completes this reconsideration.

IF YOU DO NOT REQUEST A REVIEW, THE HOSPITAL MAY BILL YOU FOR ALL THE COSTS OF YOUR STAY BEGINNING WITH THE THIRD DAY AFTER YOU RECEIVE THE NOTICE OF NONCOVERAGE. THE HOSPITAL, HOWEVER, CANNOT CHARGE YOU FOR CARE UNLESS IT PROVIDES YOU WITH A NOTICE OF NONCOVERAGE.

HOW TO REQUEST A REVIEW OF THE NOTICE OF NONCOVERAGE

- If the Notice of Noncoverage states that your physician agrees with the hospital's decision:
  - + You must make your request for review to the PRO by noon of the first work day after you receive the Notice of Noncoverage by contacting the PRO by phone or in writing.
  - + The PRO must ask for your views about your case before making its decision. The PRO will inform you by phone or in writing of its decision on the review.
  - + If the PRO agrees with the Notice of Noncoverage, you may be billed for all costs of your stay beginning at noon of the day after you receive the PRO's decision.
  - + Thus, you will not be responsible for the cost of hospital care before you receive the PRO's decision.
- If the Notice of Noncoverage states that the PRO agrees with the hospital's decision:
  - + You should make your request for reconsideration to the PRO immediately upon receipt of the Notice of Noncoverage by contacting the PRO by phone or in writing.
  - + The PRO can take up to three working days from receipt of your request to complete the review. The PRO will inform you in writing of its decision on the review.
  - + Since the PRO has already reviewed your case once, prior to the issuance of the Notice of Noncoverage, the hospital is permitted to begin billing you for the cost of your stay beginning with the third calendar day after you receive your Notice of Noncoverage even if the PRO has not completed its review.
  - + Thus, if the PRO continues to agree with the Notice of Noncoverage, you may have to pay for at least one day of hospital care.

NOTE: The process described above is called "immediate review." If you miss the deadline for this immediate review while you are in the hospital, you may still request a review of Medicare's decision to no longer pay for your care at any point during your hospital stay or after you have left the hospital. The Notice of Noncoverage will tell you how to request this review.

POST-HOSPITAL CARE

When your doctor determines that you no longer need all the specialized services provided in a hospital, but you still require medical care, he or she may discharge you to a skilled nursing facility or home care. The discharge planner at the hospital will help arrange for the services you may need after your discharge. Medicare and supplemental insurance policies have limited coverage for skilled nursing facility care and home health care. Therefore, you should find out which services will or will not be covered and how payment will be made. Consult with your doctor, hospital discharge planner, patient representative and your family in making preparations for care after you leave the hospital. Don't hesitate to ask questions.

ACKNOWLEDGMENT OF RECEIPT-My signature only acknowledges my receipt of this Message from (name of hospital) on (date) and does not waive any of my rights to request a review or make me liable for any payment.

_____ _____

Signature of beneficiary or person acting on behalf of beneficiary

(Date of receipt)

INDEX

* U.S. G.P.O. 1992-312-138:60007

OTHER PUBLICATIONS ABOUT MEDICARE

Guide to Health Insurance for People with Medicare (518-Y)

Discusses what Medicare pays and does not pay, types of private health insurance to supplement Medicare and gives hints on shopping for private health insurance.

Medicare: Hospice Benefits (508-X)

Describes the scope of medical and support services available to Medicare beneficiaries with terminal illnesses.

Medicare and Coordinated Care Plans (509-X)

Describes the health services available to beneficiaries from health maintenance organizations (HMOs).

Medicare: Coverage for Second Surgical Opinion (557-Y)

Explains the importance of getting a second opinion for non-emergency surgery, describes Medicare coverage of costs, and gives suggestions for locating a specialist in your area.

Medicare: Employer Health Plans (520-Y)

Explains the special rules that apply to Medicare beneficiaries who have employer group health plan coverage.

Medicare Coverage of Kidney Dialysis and Kidney Transplant Services: A Supplement to Your Medicare Handbook (519-Y)

Describes Medicare benefits for people with permanent kidney failure.

Manual De Medicare (642-X)

The Spanish language handbook.

To order a copy of one or more of these free publications, fill out and mail the order form at the bottom of the page to:

Consumer Information Center
Department 59
Pueblo, CO 81009
Supplies may be limited. Allow 6 to 8 weeks for delivery.

Please cut here and mail

Check the booklets you want, fill in your name and address, and send this order form to: Consumer Information Center, Department 59, Pueblo, CO 81009.

- ☐ Guide to Health Insurance for People with Medicare (518-Y)
- ☐ Medicare: Hospice Benefits (508-X)
- ☐ Medicare and Coordinated Care Plans (509-X)
- ☐ Medicare: Coverage for Second Surgical Opinion (557-Y)
- ☐ Medicare: Employer Health Plans (520-Y)
- ☐ Medicare Coverage of Kidney Dialysis and Kidney Transplant Services (519-Y)
- ☐ Manual De Medicare (642-X)

Name _____

Address _____

_____

City _____

State _____ Zip _____

U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
6325 Security Boulevard
Baltimore, Maryland 21207

Official Business
Penalty for Private Use, $300

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